The Recovery Experience of Service Users in Substance Use Treatment with Co-occurring Anxiety and Depression

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Abstract

Substance misuse and mental disorders often co-occur together, the most prevalent of which are anxiety and depression. However, despite the prevalence of co-occurring disorders among service users in treatment, there is still a lack of understanding surrounding this relationship and treatment prospects remain poor. The current thesis utilises qualitative methodology; namely, participant observation and semi-structured interviewing, to examine the relationship between mental illness and substance misuse, and explore the recovery experience of those service users with co-occurring anxiety and depression. Nine participants (consisting of both service users and peer mentors) with experience of co-occurring anxiety, depression and substance use problems were sampled for interviewing using purposive and volunteer sampling.

The chapters of this thesis examine factors that facilitate the onset of substance use problems; barriers to recovery prospects; the role of communal, activity-based programs such as the DOMINO project in reducing substance use and improving mental health; and the importance of peer-support and helping others within recovery.

The thesis concludes with three key arguments: (1) substance misuse, anxiety and depression are intrinsically linked, and have a cyclical and self-perpetuating relationship; (2) peer support is an invaluable asset to those with co-occurring anxiety and depression, as it helps develop recovery capital and is a crucial source of hope, motivation and guidance in the recovery process; (3) despite apprehension surrounding returning to work, the notable desire of service users to help others, particularly those with similar lived experience to their own, may offer a pathway toward future employment and help service users sustain their own recovery and develop a sense of meaning and purpose.

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Introduction

Substance use is a substantial and pervasive problem in the UK and throughout the world. In England and Wales, around three million (1 in 11) people aged between 16 and 59 reported taking an illicit drug in the past year; of these, around half reported using one in the last month (Home Office, 2018). With regard to alcohol, these levels are much higher, with over 10 million people in England and Wales drinking above the recommended number of units (Burton *et al*., 2016). Substance misuse[1] is associated with a multitude of health problems, and an increased risk of mortality. In England and Wales, deaths related to illicit substance use are at their highest level since comparable records began in 1993 (NHS Digital, 2019), and around 1 in 20 deaths in Wales are attributed to alcohol every year (Gartner, Francis, Hickey, Hughes and May, 2014).

In addition to physical health problems, substance misuse is also significantly associated with mental illness (Petersen and McBride, 2002; Abou-Saleh and Janca, 2004; Flynn and Brown, 2008; Walters, 2013; Sue, Sue, Sue and Sue, 2016; Strang *et al*., 2017). A recent report by Public Health England cited that 70% of drug users and 80% of alcohol users in substance use services also experience mental health problems (Christie, 2017). In Wales, three out of four (75%) of those with substance use problems also have a co-occurring mental illness (Reese *et al*., 2015).

Terminology

'Co-occurring Disorders'

The co-existence of a mental illness and substance use disorder[2] is described under a number of different terms in the literature, including 'co-occurrence', 'comorbidity' and 'dual-diagnosis'. However, the term 'dual-diagnosis' was avoided in this research, as it implies the

[1] For the purposes of this review, the term substance misuse will be used interchangeably with the term 'substance use disorder', which is defined below

[2] The DSM-V (Diagnostic and Statistical Manual of Mental Disorders, fifth edition) defines a substance use disorder as: "a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (American Psychiatric Association, 2013: 483)

presence of only two disorders, where in fact it is likely that service users present with multiple disorders (Drake *et al*., 2001; Daley and Moss, 2002; Sacks, Ries and Ziedonis, 2005). Manley (1998) goes so far as to describe the term as a "misnomer" given that service users are rarely formally diagnosed with both a substance use and a mental disorder (cited in: Petersen and McBride, 2002: 267). Furthermore, it is important to note that the American Psychiatric Association [APA] definition of a 'substance use disorder' is largely based on the biomedical model. This is somewhat problematic as although recent research has highlighted that substance use disorders are chronic and relapsing conditions (Murthy *et al*., 2016) and prolonged use has profound neurobiological consequences (Murthy *et al*., 2016; Volkow, Koob and McLellan, 2016), this model diminishes the social and psychological influences on substance use behaviour that will be discussed later in this review.

The current research will adopt the term 'co-occurring disorder' to describe those who suffer concurrently with a substance use problem and a mental illness, as this is the most common term used within contemporary literature (Flynn and Brown, 2008; Mueser, Drake, Sigmon, and Brunette, 2008; Pallaveshi, Balachandra, Subramanian and Rudnick, 2014; Priester, Browne, Iachini, Clone and Seay, 2016; Bradizza, Ruszczyk, Dermen, Lucke and Stasiewic, 2018). However, while the term 'co-occurring disorder' is an improvement from previous terms and will be used throughout this thesis for ease of communication, it does have limitations. Namely, the word 'disorder' (and the use of medicalised terms throughout the substance use and mental illness literature generally) risks placing too much emphasis on the biomedical model, despite the fact that both mental illness and substance use problems have prominent socio-environmental, socio-economic and psychological influences (which are discussed later in this review). Additionally, the term would seem to exclude those who lack a formal diagnosis of their mental illness as the term 'disorder' is usually reserved for those who have received a formal diagnosis from a medical professional, which is problematic given research suggests many of those with mental illnesses lack a formal diagnosis (Nutt, 2012; Davey, 2016; Walters, 2013).

The categorical approach promoted by the DSM[3], while useful for communication between professional and non-professionals, risks devaluing the multi-dimensional nature of mental illness (Flynn and Brown, 2008). Simply put, over-reliance on categorical approaches eliminates nuance from the equation. Humans are complex and multi-faceted, and as such, any categorical definition that implies uniformity is likely to miss important aspects of the problem (Ingram, Atchley and Segal, 2011). Khoury, Langer and Pagnini (2014) argue that the biomedical model promoted by the DSM and the innate character defects that it implies are the cause of mental disorders, fail to consider the social, economic and political context in which they develop. Further, they note that diagnostic criteria and the inherit labelling which accompanies it, is also problematic as labels are powerful and can promote self-fulfilling prophecies once attached. Therefore, categorical approaches to mental illness should generally be approached with some caution, and time should be taken to differentiate between a mental illness and normative reactions to life stress (Stein, Phillips, Bolton, Fulford, Sadler and Kendler, 2010). As Drake, Wallach and McGovern (2005: 1297) note: "When it comes to substance use, we need to keep in mind that people with mental illnesses, like the rest of us, are human agents, not just passive sites of biomedical conditions".

It is also important to note from the outset that the term co-occurring disorder will be used in three separate contexts within this thesis: 1) The co-occurrence of a substance use problem and mental illness; 2) the co-occurrence of anxious and depressive disorders; 3) the co-occurrence of a substance use and an anxious and depressive disorder, specifically. These will be labelled co-occurring (a), co-occurring (b) and co-occurring (c), respectively.

'Mental Health' and 'Mental Illness'

It is also important to clarify two terms that are often used interchangeably but have been empirically validated as distinct entities (Slade, 2010): mental illness and mental health. Mental illness often refers to a diagnosed mental disorder, usually involving "significant changes in thinking, emotion and/or behaviour" and "distress and/or problems functioning in social, work or family activities" (American Psychiatric Association [APA], 2019: 1). Mental health however, is different. The World Health Organisation [WHO] (2005: 12) define mental

[3] DSM is an abbreviation for the Diagnostic and Statistical Manual of Mental Disorders

health as: “a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. The definition is comprised of three primary elements: self-actualization[4], resilience and personal and social competency.

The distinction between the two is important as it points to the fact that mental health treatment should support not only the reduction of mental illness but the improvement of mental health (Slade, 2010). While the two are related, mental health is more than just the absence of a mental illness such as anxiety or depression. Good mental health is conditioned on a state of wellbeing[5] (Westerhof and Keyes, 2010) that involves individual resilience and self-actualisation, rather than simply a state of happiness (Ryff and Keyes, 1995). Keyes (1998) also highlighted the importance of social functioning and social engagement in wellbeing (cited in: Westerhof and Keyes, 2010) and stated that it was the combination of emotional, psychological and social wellbeing that defined good mental health (Keyes, 2005). Importantly, Keyes (2005: 546) noted that mental illness and mental health do not lie on opposite ends of a single continuum but rather “constitute distinct but correlated axes”. For example, he noted while mental illness when combined with poor mental health was “markedly worse” then pure mental illness, individuals could have a mental illness and have some measure of good mental health (p. 546). This conclusion has been supported by contemporary research highlighting that strong levels of positive mental health serve as a protective factor against the development of mental illness, while poor levels of positive mental health increase the risk of developing mental illnesses such as depression (Iasiello, Agteren, Keyes and Muir-Crochrane, 2019). Improving mental health is therefore an important element of the treatment of mental illness and health care systems designed on the assumption that mental illness and mental health lie at opposite ends of the same continuum risk providing reactive care that further stigmatises the disorder and increases the fear that surrounds it (Iasiello, *et al*., 2019).

[4] Self-actualisation refers to an individuals’ ability to realise their talents and potential and their drive to pursue and fulfil these needs. It was brought to prominence as the final level of Maslow’s Hierarchy of Needs theory within his study on human motivation (Maslow, 1943)

[5] Wellbeing is discussed in more depth later in the chapter

Confusingly, the term 'mental health problem' is also used to refer to those with a diagnosed mental illness (MIND, 2019), as this is perceived to be less stigmatising and indeed, is part of the reason that treatment services are described as 'mental health services', as opposed to 'mental illness services'. Additionally, the term may also be used to avoid over medicalising problems (especially in the case of anxiety and depression, which have strong social, environmental and political influences[6]) that can often result as a natural reaction to adverse life experiences, as opposed to an innate brain disfunction (Hari, 2016). This is a valuable approach to the discussion of mental illness as medicalised labels can have profound consequences on an individual's self-perception and can become self-reinforcing (Khoury, Langer and Pagnini, 2014). However, especially in academia, it is difficult to use the term 'mental health problem' in its intended context given that, as highlighted above, mental illness and mental health are connected but distinct entities. Therefore, despite its limitations, the terms mental illness and mental disorder are used in its place to ensure the intended meaning is conveyed[7]. However, some participants may refer to their 'mental health problem', whereas in light of the distinction provided above, they are in fact referring to a mental illness. Where this is the case, I have used their terminology in my analysis as it would be inappropriate to alter their response to incorporate the academic distinction between the two.

'Treatment' and 'Recovery'

Before embarking further into this thesis, it is also important to consider and define two fundamental terms found in the substance use field, and to delineate between them: *Treatment* and *Recovery*. While treatment is beneficial in initiating recovery, it "does not necessarily guarantee behaviour change" as research suggests that long-term recovery is conducive on a broader range of additional factors (Best, McKitterick, Beswick, Savic, 2015: 271). Strang and colleagues (2017: 59) suggest that the treatment-to-recovery journey can be "broadly conceptualized as a general transition from managing risks to building strengths and recovery capital"[8]. This is why it is important to broaden the "investigative scope" within the research and treatment sphere, to concentrate not just on predictors of recovery initiation,

[6] This is discussed in greater depth later in the chapter
[7] 'Mental health treatment' is still used to refer to treatment services for those with mental illness
[8] The concept of Recovery Capital is discussed in greater depth later in Chapter One

but recovery maintenance; such as, social support or finding meaning in life (Laudet and White, 2008: 28). Treatment and recovery are "equally important and not mutually exclusive" (Best, McKitterick, Beswick and Savic, 2015: 279), one often informs and promotes the other.

For the purposes of this thesis, 'treatment' is defined as any professional attempt to address an individual's substance use through structured interventions, this would include interventions such as Cognitive Behavioural Therapy (CBT) or the Minnesota Model. 'Recovery', however, is more difficult to define. Despite the prevalence of the term in the literature, there is no universally accepted definition (Neale, Nettleton and Pickering, 2013; Best, Beckwith, Haslam, Haslam, Jetten, Mawson and Lubman, 2016) given its inherently subjective nature. Nevertheless, recovery is often described as a personal journey of transformation and growth toward a healthier and more fulfilling way of life, which embraces the pursuit of meaning and purpose and may or may not involve abstinence.

The UK Drug Policy Commission (2008: 6) defines recovery as "voluntarily sustained control over substance use, which maximises health and wellbeing and participation in the rights, roles and responsibilities of society. Similarly, Best and colleagues (2016*a*) identify recovery as a personal journey through which an individual's identity is re-moulded through interaction with new recovery-oriented social networks who mediate this change through a process of social learning and control and through engagement in newfound meaningful activities. This process guides the individual along a path in which their internalised 'addict identity' is supplanted with a new, more positive identity, free of the socially stigmatised connotations associated with problematic substance use. The notable difference in Best and colleagues' (2016*a*) definition is the emphasis placed on the role that community plays in the recovery process (i.e. in the development in recovery-oriented social networks), which is a point highlighted in the current research project and is discussed at length in Chapters Five and Six. While no accepted definition is available for recovery, it is clear that it is unlikely to be a quantitatively defined outcome to be achieved but rather a deeply personal journey toward a more fulfilling way of living (Slade, 2010).

In a similar fashion to the distinction between mental illness and mental health, treatment and recovery do not lie at opposite ends of a single continuum, but rather they

constitute distinct but correlated axes. The distinction between these two terms is not always clear-cut and they often overlap significantly. For example, an intervention such as group therapy can have both recovery and treatment elements – the intervention may provide treatment on appropriate ways to manage substance use and poor mental health using CBT principles, while the social element of the group can help develop the support networks necessary to sustain recovery. In this sense, recovery signifies the journey while treatment often refers to the process.

This research was conducted in conjunction with a treatment service and is therefore aimed at improving these services for individuals with co-occurring disorders (c). Therefore, I have placed emphasis on suggesting factors that treatment services may benefit from considering or promoting when operating their service. This is not intended to obfuscate the delineation between treatment and recovery. In fact, in the majority of cases, the factors I emphasise as important for treatment services to consider are also conducive to sustaining recovery and indeed, this is why I have highlighted them.

The Research Focus

A recent European report noted that the detection and treatment of co-occurring disorders (a) was one of the biggest challenges that clinicians, professionals and policymakers working within the field must face (Torrens, Mestra-Pintó, Domingo-Salvany, Montanari and Vicente, 2015). This issue is a difficult but important challenge to tackle, owing to the high costs that co-occurring disorders (a) create for society in terms of their burden on the health and legal systems (Torrens *et al*., 2015; Murthy *et al*., 2016).

While most of the review below utilises research on co-occurring disorders (a) generally owing to a lack of information exclusively relating co-occurring disorders (c), Flynn and Brown (2008) note that there is need for research to place more focus on specific disorders. The literature consistently highlights anxiety and depression as the most prominent conditions to co-occur with substance misuse (Eckleberry, 2004; Torrens *et al*., 2015; Davey, 2016; Christie, 2017; Strang *et al*., 2017), and therefore the current research project will

examine the co-occurrence of substance use problems among those with anxiety and depression in substance use treatment.

The Value of the Current Research

Despite an awareness of the pervasiveness of co-occurring disorders (a), treatment for this group still remains inadequate (Torrens *et al*., 2015) and there is a need for a focus on specific disorders (Flynn and Brown, 2008). Moreover, despite the prevalence of co-occurring disorders (a) in the UK (Welsh Government, 2015; Christie, 2017), much of the research on the topic has been conducted in other countries, with most literature deriving from American studies (Welsh Government, 2007). As such, there is a gap in addressing this topic from a UK perspective. Furthermore, the National Institute for Health and Care Excellence (NICE) (2016) emphasise the importance of involving those experiencing treatment in the research process. However, there remains a lack of qualitative research that has sought to engage with service users and peer mentors directly regarding their recovery experience.

This research therefore, aims to engage directly with service users and peer mentors with co-occurring (c), to seek their experiences of recovery and perspectives on the treatment process. The qualitative approach will provide a rich and textured data set that may help the field better understand the relationship between mental illness and substance misuse, and improve treatment and recovery prospects for this group in the future.

Aims and Objectives

This study aims to examine the recovery and treatment experience of those with a history of co-occurring disorders (c). It will explore what factors influence the development and maintenance of substance use problems among this group, and highlight what elements of the treatment process that are particularly beneficial, or warrant improvement. It also aims to explore the relationship between mental illness and substance misuse.

Research Question

The overarching research question for this project is:

How is recovery experienced and understood by those with co-occurring anxiety and depression?

To address this question, the following themes will be explored:

1. What are service users experience of the treatment process?
    - What factors do service users believe facilitated their drug use?
    - What barriers to recovery do service users experience?
    - What do service users value from treatment?
2. To provide a contextual basis for the data, the life history of interview participants will also be examined

Research Objectives

To engage with service users and peer mentors, using qualitative methodology, to explore:

- Factors which facilitate the onset of substance misuse problems
- The relationship between anxiety, depression and substance misuse
- How those with co-occurring disorders (c) experience the recovery process
- The perspectives of those with co-occurring disorders (c) regarding the treatment they receive for their mental illness and substance use problem

Methodology

This project will use a qualitative methodological approach and an interpretive epistemology to address the research questions outlined above. The close proximity afforded through a qualitative approach will help build trusting relationships between participants and myself, which will help facilitate the data collection process and establish a rich data set, imbued with nuance and texture.

The research methods used in this study will be participant observation and semi-structured interviewing. Participant observation will provide first-hand experience of the treatment process of those with co-occurring disorders (c) and provide an opportunity to begin to develop trusting relationships with staff and service users. Semi-structured interviewing will provide the flexibility necessary to delve into the complex and multi-dimensional lives of participants, and allow for unconsidered avenues to be explored.

The importance of ethical consideration is vital to this project, given my close proximity to the research participants and their vulnerable state. These ethical considerations will be expanded on in depth within the methodology chapter of this thesis. However, before this project began the ethical approval of Aberystwyth University's Ethics Committee was sought and received.

Overview of the Thesis Structure

Chapter One: Chapter one of this thesis explores and reviews the existing literature on the topic of co-occurring disorders (a & c). It is divided into five broad sections: To begin, the review provides a brief corollary overview of the problem of co-occurring disorders (a) to follow on from the introductory section of this thesis. Secondly, the chapter highlights anxiety and depression as the most pervasive disorders to co-occur with substance misuse, and considers the symbiotic relationship between anxiety and depression. Third, the chapter examines two common pathways through which co-occurring disorders (a) develop. The first pathway relates to shared risk factors that are present in mental illness and substance use problems. The second pathway explores mental illness as a risk factor in the development of substance use problems, and discusses the self-medication hypothesis and the neurobiological impact of prolonged drug use. Fourth, the chapter examines common barriers to recovery highlighted by previous research, including negative affect, feelings of boredom and isolation, peer-pressure and poor wellbeing. Finally, the chapter examines a number of treatment interventions that have been highlighted as beneficial in the treatment of service users with co-occurring disorders. These include peer support, which encompasses group interventions and peer mentoring, Cognitive Behavioural Therapy, Behavioural Activation and

mindfulness-based interventions. This section also considers the concept of Recovery Capital and the role of wellbeing models in treatment. The chapter explores the evidence for the efficacy of these approaches in treating service users with co-occurring disorders (a & c).

Chapter Two: Chapter two expands upon the methodology brief detailed above. This chapter describes the rationale behind adopting a qualitative methodology for this project, and details the methods utilised to explore the research questions posed. The chapter then details the topics covered during the interviews, and the analysis process of the data. Finally, the chapter addresses the importance of ethics in qualitative work, especially among vulnerable populations, and concludes with a number of reflections on the research process.

Chapter Three: Chapter three examines common factors that participants described as facilitating the onset of their substance use problem and explores the relationship between substance misuse, anxiety and depression. The chapter identifies that managing anxious and depressive symptoms, trying to augment poor self-esteem and dealing with the thoughts and emotions associated with a traumatic history as prominent factors influencing the development of co-occurring disorders (c). The chapter also discusses service users' frustration at being unable to secure psychological therapy through the NHS and suggests this has an exacerbatory impact on both their mental illness and substance misuse. The chapter concludes with implications for the treatment process; highlighting the intrinsic relationship between mental illness and substance misuse, and the importance of simultaneous treatment for both disorders.

Chapter Four: This chapter explores a number of barriers that participants described as being problematic for their recovery. Similar to the previous chapter, these barriers broadly related to their exacerbatory effect on participants mental illness. The chapter begins by discussing the problem of re-engaging with drug-oriented friends; next the chapter examines how feelings of loneliness or boredom may exacerbate anxious and depressive symptoms and precipitate relapse. Following this, the negative (and possibly positive) impact of stigmas are examined with reference to their role in exacerbating depressive symptoms and motivating service users to seek treatment, respectively. Finally, the chapter discusses service user

conflict with the Department of Work and Pensions in regards to their recovery and employment.

Chapter Five: This chapter focuses on the DOMINO Project. It examines the efficacy of this type of intervention and the role that sociable, diversionary activities play within treatment, recovery and improving mental health. The chapter explores its role in addressing feelings of isolation, and following evidence from the previous chapter, highlights the importance of socialisation in recovery. Next, the chapter discusses DOMINO's role in facilitating the establishment of recovery-orientated social networks and the important support these provide. The chapter then examines the importance of structure and routine within the daily lives of service users and suggests that regular, time-tabled, activity-based interventions may help build this. The chapter then concludes by examining the efficacy of DOMINO in promoting wellbeing and the importance of this in recovery.

Chapter Six: Chapter Six explores the importance of peer support within the recovery process of service users with co-occurring disorders (c). It begins by examining the importance of relatability within treatment, and suggests that the appreciation of shared experience with those in treatment and recovery helps to ameliorate feelings of stigma related to their drug use, mental illness and life history. The chapter then examines the role of group work as a treatment approach, and explores the benefits and possible limitations of the approach. The role of peer mentoring is then discussed, with reference to its role in encouraging motivation and fostering a sense of hopefulness, and also its efficacy in solidifying the recovery of the peer mentors themselves. Finally, the chapter explores the role that meaningful work may play in the recovery process of service users with co-occurring disorders (c), with reference to the desire of service users to pursue employment opportunities that revolve around helping others, or "giving back".

Chapter Seven: The final chapter of this thesis begins by outlining the research aims and objectives of the current study with reference to the research question posed at the outset of this project. It offers a brief summary of the findings of the literature review and the methodological approach taken, and then identifies and discusses the three key findings of this research and their implications for treatment services. Namely, the intrinsic and

synergistic relationship between mental illness and substance misuse; the prominent and vital role that peer support plays in the recovery process; and the notable desire of service users to “give something back” and help others, and the potential to capitalise on this desire as a pathway toward employment, once service users have stabilised their recovery.

The chapter concludes by highlighting a few limitations of the current study, such as its small sample size and focus on a limited geographical area, and then outlines a number of avenues that future research may benefit from investigating.

Chapter One: The Problem of Co-occurring Disorders

This review will illustrate the problem of co-occurring disorders (a) and the challenges they present for treatment, using research from various countries including the United States, as this is where the majority of research on the subject has been conducted (Crome, Chambers, Frisher, Bloor and Roberts, 2009).

The literature review is divided into five main sections. Firstly, it begins by examining the problem of co-occurring disorders (a) and highlights anxiety and depression as the most prominent disorders. Secondly, it discusses common pathways through which co-occurring disorders (a) develop with reference to both internal and external stressors. Thirdly, it highlights two primary pathways through which co-occurring disorders (a) develop. Fourthly, it examines common barriers to recovery and their effects on relapse rates. Finally, this review will explore a number of treatment interventions that have shown promise in treating those with co-occurring disorders (a), including peer support interventions, CBT, Behavioural Activation therapy and mindfulness-based interventions.

Co-occurring disorders (a) present a considerable challenge for treatment services (Hawkins, 2009) given their synonymy with poor treatment prospects for both conditions (Strang *et al.*, 2017), and negative impact on quality of life (Torrens *et al.*, 2015). Those with co-occurring disorders (a) are more likely to suffer from poor physical and mental health (Christie, 2017) and are also at an increased risk of hospitalisation, relapse, unemployment, homelessness and suicide (Petersen and McBride, 2002; Torrens *et al*., 2015; Welsh Government, 2015; NICE, 2016; Christie, 2017; Motta-Ochoa *et al*., 2017; Strang *et al*., 2017). These disorders seem to have a synergistic and cyclical relationship, and treatment success remains low unless both disorders are treated (Flynn and Brown, 2008; Torrens *et al*., 2015).

Anxiety and Depression as the Predominate Conditions

Anxiety and depression are consistently highlighted as the most prevalent disorders associated with substance use problems (Essau, 2002; Eckleberry, 2004; Rachman, 2004;

Rokach, 2005; Flynn and Brown, 2008; Delgadillo, Godfrey, Gilbody, Payne, 2012; Torrens *et al*., 2015; Davey, 2016; Christie, 2017; Strang *et al*., 2017) and are often underlying symptoms of a number of other disorders (APA, 2013). Indeed, previous authors have concluded that the co-occurrence of internalising disorders[9] (i.e. anxiety and depression) and substance use should be considered the rule, rather than the exception (Lai, Clearly, Sitharthan and Hunt, 2015).

Anxiety and depression also frequently co-occur with one another (Hirschfeld, 2001; Ingram, Atchley and Segal, 2011; APA, 2013; Collimore and Rector, 2014; Davey, 2016; WHO, 2017). For example, results from the National Comorbidity Survey in America found that 57.5% of those with major depressive disorders also met the criteria for an anxiety disorder within 12 months (cited in: Collimore and Rector, 2014), and similar rates of depression have been highlighted among those with anxiety disorders (Collimore and Reactor, 2014). Given how interwoven anxiety and depression often are, some researchers have argued that they are in fact not independent disorders but "subcategories of a larger group of emotional disorders" (Watson, 2005, as cited in: Davey, 2016: 200). The significant underlying similarities between the two disorders has led to the concept of "internalising disorders", to explain the symbiotic relationship between them (Merrell, 2008). Merrell (2008: 12) explains that the term "comorbidity", to describe the co-occurrence of anxiety and depression, is problematic as it risks overlooking the fact that these disorders often "nurture and sustain each other, and may have developed through similar events, predispositions, and patterns of responding". Notably, substance use may fit quite well into the relationship described above, and may perhaps present as an additional facet of the symbiotic relationship described, given the synergistic relationship that has been identified between mental illness and substance misuse (Torrens *et al*., 2015).

In a recent multi-national study (Lai, Clearly, Sitharthan and Hunt, 2015), the authors conducted a systematic review of 115 articles, and a subsequent meta-analysis of 22 surveys, which described prevalence rates of co-occurring disorders (c) in the general population of a

[9] This subset of disorders refers to those in which the symptoms are focused inward, on the individual, and involve 'internal' distress e.g. the social withdrawal associated with depression. This is to differentiate them from more overtly disruptive behaviors associated with externalising disorders, such as aggression

variety of countries, including the UK. The authors found that the most prevalent disorders associated with alcohol and illicit drugs are anxious and depressive disorders, and prevalence is not limited to geographical location (Lai *et al*., 2015). Studies used in the meta-analysis were of high methodological quality; however, the authors highlighted that many diagnoses were based on lay interviews, which may have inflated the prevalence of such disorders. Nevertheless, results are consistent with other studies cited in this review, and provide further evidence for the interwoven relationship between substance use, anxiety and depression.

Prevalence rates range across studies, but are consistently high. Some studies suggest that 32-41% of those with depression, and 24-38% of those with anxiety disorders have a co-occurring substance use problem (Kessler *et al*., 1994, Regier *et al*., 1990, cited in: Ekleberry, 2004), whereas a more recent report cited much higher rates of up to 80% for depression but similar rates for anxiety (35%) (Torrens *et al.*, 2015). Nevertheless, the evidence supports a significant relationship between anxiety, depression and substance use at rates much higher than those found in the general population. Previous research suggests that those with substance use disorders are 4.7 times more likely to suffer from an affective disorder compared with the general population (Ross *et al*., 2016). However, the statistically high rates of depression and anxiety are somewhat skewed by the fact that intoxication and withdrawal from substance use often mimics the symptoms of anxiety and depression, although such symptoms may not represent an independent condition (Torrens *et al*., 2015; Murthey *et al*., 2016).

The Epidemiology of Co-occurring Disorders

The relationship between substance misuse and mental illness is complex and multi-faceted. As Alverson, Alverson and Drake (2001: 12) note:

> "To ask what 'motivates' or 'causes' an individual, whether mentally ill or not, to use or continue using drugs, or contrariwise, to stop and get a stable, abstinent life, is to ask extremely complicated questions about a person's life as a whole."

The relationship between mental illness and substance use is still poorly understood (Lai *et al*., 2015). Arguments behind its pervasiveness range from an underlying risk factor, to a causal relationship between the two (Abou-Saleh and Janca, 2004). Nevertheless, an appropriate understanding of how substance use problems develop is crucial to the development and implementation of appropriate treatment interventions (Drake, 2012).

Addiction is a problem that has blighted academia for several decades and despite the development of a multitude of theories concerning its epidemiology, it remains an elusive problem (Alexander, 2010). Similarly, the relationship between mental illness and substance use has also been difficult to decipher (Lai *et al*., 2015), and remains problematic within treatment settings (Torrens *et al*., 2015). While the numerous theories of how and why addiction develops are too extensive to be detailed justifiably within this review[10], the literature highlights two primary pathways through which co-occurring disorders (a) develop, which will be examined in this section:[11] (1) Shared vulnerabilities, such as stress, and socio-economic and socio-environmental factors and; (2) a mental illness acting as a risk factor in the development of a substance use disorder. These two pathways and discussed below in more detail.

The Adversity Pathway

Shared Vulnerabilities: Stress

Stress has profound biological, psychological and behavioural implications (Davis, Berry, Dumas, Ritter, Smith, Menard and Roberts, 2016), and is associated with a number of adverse health outcomes, including increased levels of anxiety (Alim *et al*., 2012), depression (Caspi *et al*., 2003; Alim *et al*., 2012) and substance use (Laudet, Morgen and White, 2006; Alim *et al*., 2012; West and Brown, 2013; Murthy *et al*., 2016). So significant is the relationship

[10] A multitude of theories regarding the development of substance use problems have been reviewed in great detail in West and Brown (2013)

[11] There is significant overlap surrounding explanations for the relationship between mental illness and substance use, and with substance use problems generally. This is part of the reason behind the rationale of a linear progression between the two. The two pathways described in this section were chosen due to their prominence in the literature and their ability to encapsulate a variety of theories. For example, as described later in the section, the possible relationship between the self-medication theory and disease model of addiction.

between stress and these conditions that some authors have described them as stress-related disorders (Alim *et al*., 2012). This suggests that there may be common underlying vulnerabilities to substance use and affective disorders, given that the risks associated with the development of stress-induced mood and anxiety disorders are positively associated with the risk of developing substance use disorders (Polter and Kauer, 2014). One theory posits that individuals with co-occurring disorders (a) tend to have increased exposure to stressful life experiences (Garland, *et al*., 2016), which can be both as a cause and consequence of their co-occurring disorder (a). As a result, many of them turn to substance use as a coping mechanism (Khantzian, 1997; 2003).

Sinha's (2008) study and literature review on the role stress plays within addiction is both illuminating and thorough. The author highlights that stress plays a significant role in the development of and relapse into addiction, depression and anxiety, and increases the likelihood of drug self-administration. Substance misuse and stress both induce neuroplasticity[12] of the same areas of the brain, changing the stress and dopaminergic pathways (e.g. reward pathways) which are involved in regulating mood, self-control and motivation. These changes not only make an individual more prone to a stress-response, but also impact on their ability to exercise self-control. Given that substance use has been associated with increased levels of social adversity (Marmot, Allen, Goldblatt, Boyce, McNeish, Grady and Geddes, 2010; Wyllie *et al*., 2012) which is itself associated with increased distress, this highlights the substantial role that distress can have on the development of and relapse into substance use, anxiety and depression.

More recently, Alim and colleagues (2012: 506) concluded that stress plays an "important" role in the development and maintenance of and relapse into substance use disorders. In an extremely detailed review of how stress, negative affect (i.e. anxiety, depression), and substance misuse impact on and interact with corresponding areas of the brain, the authors postulate that the chronic nature of addictive disorders may be rooted in the neurological impact of stress. They suggest that stress induces neuroplasticity in areas of

[12] This term refers to the ability of the brain to constantly change and adapt its structure throughout an individuals' life, based on new experiences

the brain associated with emotional regulation and affects the brain's reward system to favour drug use over naturally rewarding stimuli. They conclude that building resilience to stressful situations is of particular importance to those with substance use disorders.

There is also reference to the damaging role stress can have on the brain's development in the literature regarding Adverse Childhood Experiences (ACE's). For example, evidence suggests that experiencing chronic stress during childhood has a negative effect on biological development (e.g. neural, immune and endocrine systems) (Boullier and Blair, 2018), particularly through its impeditive effect on "cognitive, social and emotional functioning" (Danese and McEwen, 2012; Pechtel and Pizzagalli, 2011; cited in: Hughs, Bellis, Hardcastle, Sethi, Butchart, Mikton, Jones and Dunne, 2017: e356). Not only have ACE's been shown to increase the risk of developing a mental illness in adulthood and various high-risk health behaviours such as substance use (Ashton, Bellis, Hardcastle, Hughes, Mably and Evans, 2016; Hughs *et al*., 2017; Boullier and Blair, 2018), they have also been shown to have an adverse impact on educational attainment, employment and economic security (Metzler, Merrick, Klevens, Ports and Ford, 2017); all of which have been associated with both mental illness and problematic substance use.

While it would be overly reductionist to assign stress as the sole factor in the development of co-occurring disorders (a) (Polter and Kauer, 2014), it may represent a mechanism that underlies the cyclical relationship between life-adversity, mental illness and drug use. This theory has particular traction when you consider that stress seems to be both a cause and consequence of substance use and mental disorders, and that the neuroplastic changes associated with stress, substance use, anxiety and depression alter similar areas of the brain (Polter and Kauer, 2014).

Shared Vulnerabilities: The Impact of Socio-environmental and Socio-economic Factors[13]

There is also strong evidence to support the role that adverse environmental factors play in the development of substance use (Marmot *et al*., 2010; Maté, 2012; West and Brown, 2013;

[13] While the connection between deprivation, substance use and mental illness is a profound and important one, it is not the only contributing factor. Other factors such as educational attainment, employment status and housing also play a role.

Murthy *et al*., 2016; Hari, 2018), depression (Marmot *et al*., 2010; Lohoff, 2010; Wylie *et al*., 2012; Phillips, Carroll and Der, 2015; Hari, 2018) and anxiety disorders (Marmot *et al*., 2010; Wylie *et* al., 2012; Hari, 2018). Substance use and mental disorders may develop independently as a response to the same predisposing factor such as stress or childhood environment (Torrens *et al*., 2015) or more sequentially, as is discussed later in the review.

Alexander (2010; 2012) argues that in order to properly address addiction as a society, we must depart from the dominant paradigm of framing addiction as an individual disease or moral failure. Instead, he argues that addiction is an individualistic response to a societal problem, and highlights the failures of the current approach in curtailing substance use problems despite the large amount of resources that have been spent on it. The author refers to the work of the sociologist Karl Polanyi (1994) who highlighted the adverse consequences of a free-market society on the psychology of the individual given its tendency to dislocate people from a sense of meaning, purpose and belonging (cited in: Alexander, 2012). This dislocation, can lead to individuals to "manifest their misery through anxiety, depression, irresponsibility, violence and suicide" (Alexander, 2012: 1476). The author argues that addiction (in all its forms – i.e. not exclusively relating to substance misuse), results from an individual's attempt to reconcile these feelings, as it offers a substitute to their lack of psychological integration with society's free-market system and relief from the psychological distress that results from this dislocation. This process is described as 'The Dislocation Theory of Addiction' (Alexander, 2010; 2012).

Societal inequality (a defining feature of free-market capitalism) is significantly associated with adverse mental health, mental illness (Marmot *et al*., 2010; Hidaka, 2012; Murthy *et al*., 2016; Mental Health Foundation, 2016) and increased substance use (Alverson, Alverson and Drake, 2000; Petersen and McBride, 2002; Marmot *et al*., 2010; Murthy *et al*., 2016). The National Institute for Health and Care Excellence (NICE) (2016) notes that, in the UK, those with co-occurring disorders (a) are more likely to live in the most poverty-stricken areas. As one participant in Alverson, Alverson and Drake's (2001: 565) ethnographic study commented:

> "You try sittin' in an apartment with no heat and no food, sittin' out in the cold while your mother works foldin' laundry. On her feet all day at a job that didn't pay her enough to live on. My mother's a good mother. I have a family. I ain't talkin' sexual abuse, but it's abuse alright. It's called poverty."

In their extensive review for the UK government, Marmot and colleagues (2010) concluded that mental health was "profoundly" influenced by lived experience (p. 82) and that there was a "strong positive association" between drug use and social deprivation (p. 59). Therefore, it would seem that adversity is a significant factor influencing the development of substance use, anxiety and depression. Jacobson, Martell and Dimidijan (2001: 258) stated that societal status is "clearly linked to vulnerability to depression". Indeed, the associated risk factors for suicide and substance misuse are strikingly similar and may explain the high rates of suicide among service users with co-occurring disorders (a). Risk factors associated with substance use such as low socio-economic class, poor education, mental illness, poor mental health, impulsivity, stigma, unhealthy lifestyle, feelings of social isolation, lack of positive thoughts regarding the future, lack of goal re-engagement and increased adverse experiences are all associated with heightened risk of suicide (Wyllie *et al*., 2012).

An analogy provided by Maté (2012) regarding the impact of environmental factors in the development of substance use problems provides a useful perspective. He posits a thought experiment: two identical seeds are planted in opposing environments; one is raised in a healthy environment with lots of sunlight, nutritional soil and under proper irrigation; the second raised in poor quality soil with little sunlight and improper irrigation. The first seed will likely grow into a healthy version of the plant while the other is unlikely to develop into the healthy plant it should or could be – instead it is likely to become stunted and wilted (p. 188). The seed could not be blamed for not blooming in an improper environment; the seed's failure to grow would clearly be a result of the environmental factors imposed on it. The same is true for brain development. This is not to say that *all* seeds reared under these poor conditions would not bloom, but rather it is far more likely that they would not. This analogy resonates further when you consider evidence which shows that most individuals with a mental illness or substance use problem in adult life have experienced numerous adverse experiences in childhood (Ashton *et al*., 2016). Aldersen and Teicher (2008) posit that ACE's

and the stress associated with them may induce a number of neurobiological changes, which may facilitate substance use. A recent systematic review and meta-analysis on the effects of ACE's on adult health determined that individuals with at least four ACE's were significantly more likely to suffer from a mental illness and develop substance use problems in later life (Hughs *et al*., 2017). The authors also note that as ACE's tend to produce adverse health outcomes in adult life (e.g. problematic substance use, mental illness), and that these will in turn represent ACE's among their offspring, it often produces a self-perpetuating cycle that can trap families in deprivation and adversity (Hughs *et al*., 2017).

The Self-Medication Pathway, and its Relationship with the Disease Model

The second pathway is the pathway posited by Khantzian (1985), who developed the "self-medication hypothesis". This hypothesis states that substance use problems develop as an attempt to manage a mental illness and the problems associated with it (Torrens *et al*., 2015). The two central tenets of the self-medication hypothesis are that: (1) an individual uses, misuses, and develops dependency on substances because they relieve states of distress; and (2) that there is a significant amount of pharmacological specificity in terms of which drug they decide to use, based on what they are attempting to relieve, i.e. self-selection of a preferential drug to medicate a specific disorder (Khantzian, 2003). For example, Khantzian (2003) posits that heroin users are prone to violent and rageful affect and are drawn to opiate drugs for their calming properties.

Previous research has provided support for the first tenet of the self-medication hypothesis (Khantzian, 1985; 2003; Bradizza and Stasiewicz, 2003; Laudet, Magura, Vogel and Knight, 2004; Sbrana *et al*., 2005; Schofield *et al*., 2006; Bizzarri *et al*., 2009; Pettersen, Rudd, Ravndal and Landheim, 2013). For example, Bizzarri and colleagues (2009) found that persons with co-occurring disorders (a) described using substances to relieve depression, improve self-confidence or social abilities and maintain euphoric states. A more recent longitudinal study among those with co-occurring anxiety disorders found that self-medication was a significant factor in the development of substance use problems (Robinson, Sareen, Cox and Bolton, 2011). Similar results have been found for those with co-occurring disorders (c) (Sbrana *et al*., 2005). This suggests that as those who suffer from mental disorders are more prone to dysphoric states, they are more likely to engage in substance use in an attempt to

cope with this (Mueser, Drake and Wallach, 1998; Laudet, Magura, Vogel and Knight, 2004; Sbrana *et al*., 2005; Bizzarri *et al*., 2009).

The second tenet regarding drug specificity however, has received little empirical support (Mueser, Drake and Wallach, 1998; Laudet, Magura, Vogel and Knight, 2004; Sbrana *et al*., 2005; Lembke, 2012). For example, in a recent review, Drake (2012) highlighted the fact that, while there is substantial evidence that psychopathology in heroin users often occurs well before dependency develops, heroin users often present with a variety of disorders (not only those associated with anger and rage but often internalising disorders associated with hopelessness, such as depression) and rates of polysubstance use[14] are the norm, rather than the exception. This led the author to conclude that the tenet relating to pharmacological specificity for the self-medication hypothesis was unsubstantiated and tenuous. A similar conclusion was drawn by Dixon (1999), who found little evidence of drug specificity among those with co-occurring schizophrenia, but instead found that drug use followed ambient community trends.

Lembke (2013: 671) critiques the self-medication hypothesis for failing to acknowledge the "intrinsically reinforcing properties of addictive substances", and for the model's tendency to prompt treatment to focus on underlying psychopathology rather than the 'disease' of addiction. However, an acknowledgment of the biological implications of prolonged drug use does not necessarily run counter to the self-medication hypothesis, but may in fact support it. For example, there is a substantive and growing body of evidence that defines addiction as a disease of the brain resulting from persistent use of mood-altering substances of abuse (Leshner, 1997; Nutt, Robbins and Everitt, 2010; West and Brown, 2013; Taylor, Lewis and Olive, 2013; Murthy *et al*., 2016; Volkow, Koob and McLellan, 2016; Sue *et al*., 2016). Such studies describe how prolonged and persistent drug use has profound effects on brain structure and functioning, namely in terms of the brain's reward system; repeated use of certain drugs may facilitate neurobiological changes which promote addictive behaviours, such as impulsivity and decreased tolerance to stress and negative emotional states (APA, 2013).

[14] This refers to those individuals who engage with a variety of substances, as opposed to just one

Volkow, Koob and McLellan (2016: 363) describe addiction as a "self-inflicted brain disease" to which, like many other diseases, some of us are more susceptible than others given our specific genetic make-up, social-environmental upbringing and developed mental capacity. Their research articulates the process through which addictive drugs activate the reward centres of the brain associated with learning, memory and conditioning, and in doing so hijack and alter them to the point where the individual has little control over the behaviours they display in relation to the drugs they are taking. Subsequently, they describe how an anti-reward system develops. This system results in the individual no longer feeling pleasure from the drug, but instead feeling intense dysphoria due to the stress-response related to not taking it (e.g. withdrawal), and a decreased desire and motivation to pursue natural, everyday stimuli such as food and social interaction. This leads to a vicious cycle whereby consumption of the drug is necessitated to negate the negative effects of withdrawal, whilst also exacerbating the severity of the disorder in the process. This process creates intense craving responses for the drug associated with environmental cues, which can persist long after the user's drug use has stopped. This is the process which has led previous researchers to define drug addiction as a "drug induced neuroplastic disorder" (Sampedro-Piquero *et al*., in press: 1).

In light of this, it would seem that psychological (e.g. self-med) and biological theories are not mutually exclusive, but overlap significantly. For example, if substance use disorders develop through prolonged exposure to drugs (Volkow *et al*., 2016), then the more an individual relies on substance use to relieve distress (Khantzian, 2003), the more likely the substances are to exert fundamental neurobiological changes. In this sense, the 'disease' of addiction develops as a result of the primary consequence of over-reliance on drugs for psychological relief. Furthermore, given the strong evidence for the role played by socio-economic and environmental factors in the development of mental illness and substance use, it may be that mental disorders which develop as a result of adversity (Hari, 2018) may promote substance use, and in doing so, induce the disease of addiction.

Sampedro-Piquero and colleagues (in press) have highlighted that these neuroplastic changes may not be permanent and can in fact be reversed through "cognitive training",

which entails non-drug related learning experiences such as memory training, mindfulness practice and therapeutic experiences such as art and music. However, some of the evidence they present is based on animal studies, and therefore limited in terms of its relevance for humans. Nevertheless, it offers a suggestion about possible mechanisms through which CBT and mindfulness-interventions (discussed below) may be effective.

It should be noted however, that there is also a third way through co-occurring disorders (a) develop, especially in relation to mood and anxiety disorders. That is, substance use (especially during withdrawal) often replicates symptoms of mood and anxiety disorders (i.e. irritability, poor mood, feelings of anxiety) but that these may not constitute an underlying mental illness, given that they often dissipate after a period of abstinence (Torrens *et al*., 2015; Marcel *et al*., 2016). As such, careful consideration should be taken during initial assessment to determine the severity and longevity of any potential mental illness; although this is often difficult to ascertain (Sacks, Ries and Ziedonis, 2005). Nevertheless, these substance-induced disorders are still associated with poorer treatment outcomes (Marcel *et al*., 2016) and are important to consider. However, although important to consider, the current research is concerned with individuals who have a diagnosed anxiety or depressive disorder and as such, this pathway is beyond the scope of this thesis.

Barriers to Recovery

A number of studies have highlighted the high relapse rates associated with co-occurring disorders (a) (Sacks, Ries, Ziedonis, 2005; Torrens *et al*., 2015; Marcel *et al*., 2016; Welsh Government, 2015; Christie, 2017). Laudet, Magura, Vogel and Knight (2004) suggest that these high relapse rates result from an increased vulnerability to negative affect, and a decreased ability to manage it. Marcel and colleagues (2016) have also noted that depression and anxiety are significantly associated with relapse, which is often triggered by negative mood. This suggests that mental illness and substance use have a synergistic relationship and indicators of relapse among those with co-occurring disorders (a) may "not be different in type, but in kind" compared to those without a mental disorder (Davis and O'Neill, 2005:

1288). Decisions on treatment options therefore would seemingly benefit from addressing the mental illness directly, whilst improving coping skills, mental health and wellbeing.

A number of studies from the US have highlighted feelings of loneliness and boredom, interaction with drug-oriented friends, and psychological distress as prominent predictors of relapse among those with co-occurring disorders (a) (Bradizza and Stasiewicz, 2003; Laudet, Magura, Vogel and Knight, 2004; Drake, Wallach and McGovern, 2005; Harris, Fallot and Berley, 2005). For example, Bradizza and Stasiewicz (2003) conducted a qualitative, focus group study in the US in which they identified a number of risk factors associated with relapse among those with co-occurring disorders (a) (44% of whom had major depression). These included worsened psychological symptoms, engagement with peers who use drugs and alcohol, boredom and psychological distress. They noted that both positive and negative affect were risk factors, but that negative affect was a far more common trigger and comprised the vast majority of affect-related responses.

Negative Affect

Recent results from the crime survey in England and Wales found that levels of happiness were negatively associated with drug use (Home Office, 2018), and Wills and colleagues (2001) highlighted after a longitudinal study of students that an increased propensity toward positive mood was associated with resilience to substance use disorders (cited in: Alim *et al*., 2012). While the Home Office statistics were self-reported, which may have inhibited their integrity, and the generalisability of Wills and colleagues' (2001) study is limited to young adults, the findings are consistent with other research linking negative affect and substance use (Drake, Wallach and McGovern, 2005). As highlighted previously, negative emotional states are often cited as a reason for relapse among service users (Bradizza and Stasiewicz, 2003; Laudet *et al*., 2004; Harris, Fallot and Berley, 2005) and they have also been shown to lead to quicker relapse times (Sinha, Garcia, Paliwal, Kreek and Rounsaville, 2006, as cited in: Davis *et al*., 2018). A recent New York Times article, which used a qualitative methodology to depict the journey of addiction, quoted one service user to help explain the association between relapse and negative emotional states (Sinha, Leiberman, Davis, 2018):

> "Any time you start to feel like you're getting antsy or anxious or a little stressed, your body says it knows exactly how to get out of this, and it's telling you to just go get a little bit more of that heroin."

Feelings of Boredom and Loneliness

Laudet and colleagues (2004) conducted a number of qualitative interviews with service users who had co-occurring disorders (a), and found that the most frequent responses to questions regarding reasons for relapse were craving and feelings of boredom and loneliness. They also noted that feelings of stress were often associated with relapse, which supports previous evidence provided in this review. Similarly, Davis and O'Neil (2005) highlighted during focus group research that those with co-occurring disorders (a) felt it was important to avoid boredom by engaging in meaningful activities. As one participant noted when asked what was important to avoid relapse: "keeping busy and not getting bored – 'cause you don't want to start thinking about using" (p. 1290). The response suggests that treatment which focuses on engaging service users in meaningful activity may reduce relapse rates by giving them something to focus on besides drugs. Indeed, Harris, Fallot and Berley (2005: 1292) state that treatment should address "negative feelings such as boredom and loneliness" through meaningful activity. However, their study was based on women trauma survivors and thus its generalisability may be limited.

Boredom is often associated with feelings of loneliness and social isolation is consistently associated with mental illness and poor mental health (Rokach, 2005; Marmot *et al*., 2010; Hidaka, 2012; Wyllie *et al*., 2012; Nirtel, Wood and Kempa, 2017; Hari, 2018). Loneliness increases negative thought processes in depressed people and increases the likelihood that an individual will be negatively affected by life stress (Gilson, Freeman, Yates and Freeman, 2009). Interestingly, heightened levels of rumination have been associated with increased inclination to use alcohol and an increase in depressive symptoms, suggesting that substance use may be a direct result of dwelling on negative thoughts and emotions (Brewer, Bowen, Smith, Marlatt and Potenza, 2010); something that is likely exacerbated by being alone with one's thoughts. This suggests that feelings of loneliness and boredom may result in relapse through an increased tendency to ruminate, which exacerbates mental disorders and leads to drug use as a coping mechanism.

Peer Pressure

Social pressure is a powerful mechanism in affecting individual behaviour. Bradizza and Stasiewicz (2003: 164) highlighted peer pressure and interaction with drug-oriented friends as risk factors for relapse among those with co-occurring disorders (a). A number of participants in their study struggled to break-off contact with friends with whom they used to take substances and this predicted relapse. As one participant noted:

> "I was visiting old friends. I couldn't really explain why I used. I don't know, I tried to resist but then I broke down cause I was around everyone using."

The above remark seems to support evidence from Laudet and colleagues (2004), who noted that substance use often begins as a method of 'fitting in'. This suggests that encouraging service users to change their social networks is a necessary part of successful treatment and it is perhaps this mechanism which makes mutual aid groups such an appealing intervention for those with co-occurring disorders (a).

Davis and O'Neil (2005: 1290) also highlighted the need to avoid substance-associated friends as a crucial aspect of successful recovery, during their focus group study. One participant in the study noted that when he had tried to quit previously, he would start to feel good about himself and return to his old friends to "show off how good [he] looked", but this caused him to relapse:

> "My friends there said 'I miss you man'. After a while I loaned them money and they were giving me heroin."

However, while the studies cited above provide a textured account of the barriers to recovery those with co-occurring disorders (a) face, they were all conducted in America and may have less relevance in the UK.

Wellbeing

Levels of wellbeing have also been negatively associated with increased levels of alcohol use. For example, although moderate alcohol consumption has been associated with improved wellbeing compared to teetotallers (Lang, Wallace, Huppert and Melzer, 2007; Veenhoven,

2008), the same is not true for heavy drinkers who are associated with poor levels of wellbeing (Graham and Schmidt, 1999; Veenhoven, 2008; Mentzakis, Suhrcke, Roberts, Murphy and McKee, 2013). Additionally, while limited by age and cultural factors, a study on South African adolescents highlighted that environmental stressors led to diminished psychological and physical wellbeing, which in turn, led to increased smoking and alcohol use (Brook, Rubenstone, Zhang, Morojele and Brook, 2011). This suggests that wellbeing is influenced through adverse experiences, and that this diminished sense of wellbeing may lead to an increase in substance use. Moreover, increasing attention is being paid to the negative impact heavy alcohol use has on the wellbeing and mental health of individuals around those who drink heavily (Casswell, You and Huckle, 2011; Ferris, Laslett, Livingston, Room and Wilkinson, 2011; Quigg, Bellis, Grey, Webster and Hughes, 2019), an issue that resonates further when we consider the impact of ACE's discussed earlier in the thesis.

Improving wellbeing has a positive effect on both physical (Veenhoven, 2008) and mental health (Dolan, 2011). However, just as good physical health has a positive effect on wellbeing, being in poor physical health has a negative impact on subjective wellbeing (Graham, Higuera and Lora, 2011; Veenhoven, 2008; cited in: Binder and Coad, 2013). Notably, these correlations are even stronger when we substitute physical health for mental health. Mental health has been shown to have the largest and most significant effect on wellbeing levels given the interrelated nature of the two and the pervasiveness with which mental health problems impair one's life, and the difficulties associated with adapting to them (Dolan, 2011). Given the significant correlation between substance use problems and poor physical and mental health, and the relationship between mental health and mental illness, it is clear that those with substance use problems who also suffer concurrently from anxiety and depression will likely have poor levels of wellbeing. Indeed, Binder and Coad (2013) highlighted that the strongest negative impact on wellbeing resulted from problematic substance use, followed by anxiety, depression and other mental illnesses; notwithstanding the fact that these are also issues likely to be underreported in self-reported data collection.

Treatment Interventions

Similarly to those with substance use problems, those with co-occurring disorders (a) require a person-centred, holistic approach to treatment (Welsh Government, 2015; NICE, 2016; Christie, 2017). There is no 'one-size-fits-all' treatment approach for this group (Lai, Clearly, Sitharthan and Hunt, 2015) and there is still a lack of agreement with regard to the most appropriate strategies for treating those with co-occurring disorders (a) (Torrens *et al*., 2015). After a systematic review of 32 randomly controlled trials, Hunt, Siegfriend, Morley, Sitharthan and Cleary (2013) found that no one psychological treatment is superior in the treatment of those with substance use and severe mental illness. This suggests that treatment should incorporate a range of interventions that those with co-occurring disorders (a) can engage with.

While there are a vast amount of treatment approaches available to those with co-existing mental illness and substance use problems[15], detailing all of these falls beyond the scope of this thesis. Instead, included below are a number of treatment approaches that are consistently highlighted in the literature as effective in the rehabilitation of those with co-occurring disorders (a) that coincide broadly with interventions offered at the organisation with which this research is associated.

Peer Support

Peer-delivered interventions and mutual aid (Humphreys and Lembke, 2013) are evidence-based models supportive of long-term recovery (Best, De Alwis and Burdett, 2017) and comprise perhaps the most important aspect of substance use treatment (Strang *et al*., 2017). Mead, Hilton and Curtis (2001: 6) define peer support as:

> "A system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on

[15] For example, pharmacological approaches (Marcel *et al*., 2016; Subodh, Sharma, and Shah, 2018) family-based interventions (Sacks, Chandler and Gonzales, 2008; Subodh, Sharma, and Shah, 2018), residential programmes (Sacks, Ries and Ziedonis, 2005; Drake, O'Neal and Wallach, 2008) and therapeutic communities (Sacks, McKendrick, Sacks and Cleland, 2010).

> psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain."

As highlighted above, the efficacy of peer support does not come from any specific psychiatric model, but from the empathic responses of a community of people with similar lived experiences, and sharing advice with one another. Day (2003: 4) notes: "Recovery is based on the power of community – the more people are helping you, the more likely you are to succeed".

Peer support within the substance use field is derived from three main sources: informal support between service users; mutual aid group interventions, (such as 12-step groups) and peer mentoring. The latter two will be discussed in more detail below.

Group Interventions

Although membership of ostracised groups (such as those found in substance-using communities) can act as a barrier to wellbeing and recovery (Johnstone, Jetten, Dingle, Parsell and Walter, 2015), membership of groups that share pro-social aspirations produce benefits in both physical health and mental wellbeing (Jetten , Haslam and Haslam, 2012: cited in: Collinson and Best, 2019). Previous authors have identified peer support as the most significant mechanism for change within mutual aid groups (Strang *et al*., 2017). This suggests that the social aspect of group therapies may be the salient mechanism in facilitating change, as Flores and colleagues (2005: xvi) state:

> "Because human beings by nature are social beings, group therapy is a powerful therapeutic tool that is effective in treating substance abuse"

Drake, Mueser, Sigmon and Brunette (2007) argue that the peer relationships which develop through group interventions help develop new social norms and relationships to offset those associated with substance-oriented friend groups, and thus improve treatment outcomes. The authors conclude that group therapy is the most effective intervention for those with co-occurring disorders (a). McKay (2017) makes a similar point, and suggests that mutual aid groups can provide an incentive to recover and make the process more appealing

through the development of new, recovery-oriented social-circles. Davey (2016: 293) goes further to suggest that much of the success of self-help groups such as Alcoholics Anonymous (AA), may be attributable to the replacement of an old peer-group associated with drug use, with a new social network of other recovery-oriented peers. This suggests that perhaps it is the support network garnered through the programme which has the biggest impact. Indeed, a systematic review of AA found that it may not necessarily be the content or practices of the group that facilitate and sustain recovery, but rather their ability to foster supportive networks, enhance motivation and develop self-efficacy and coping skills (Kelly, Magill, & Stout, 2009).

Flores and colleagues (2005) highlight that the efficacy of group interventions lies in several areas. They can reduce feelings of isolation, provide peer-support and social pressure to change and instil hope by providing the opportunity for participants to witness others achieving recovery and a forum for sharing advice and coping strategies. As highlighted by Christie (2017), addressing feelings of isolation and developing a sense of hopefulness are key features of successful treatment for those with co-occurring disorders (a). Therefore, group interventions seem a particularly important element in the treatment of those with co-occurring disorders (c), given that isolation and hopelessness are key features of depressive disorders (APA, 2013). Similarly, Strang and colleagues (2017) state that mutual aid groups can improve coping skills and motivation for recovery, and also assist in the development of a new positive identity. They also note that the positive effects of helping others is an important benefit of such groups; a sentiment that is also emphasised by McKay (2017: 754) who described such altruistic opportunities as “highly rewarding”.

There is some evidence to suggest that 12-step groups[16] (such as Alcoholics Anonymous) may not be appropriate for those with co-occurring disorders (a). Laudet,

[16] 12-step groups or fellowships are regular meetings held by those in recovery from a variety of behavioral problems (primarily substance use, although they exist for others e.g. gambling) that are led by an experienced member of the group and follow a set of guiding principles aimed at addressing a problematic behavior. The most famous of which, and upon which the principles were founded, is Alcoholics Anonymous, a support group for those with alcohol use problems. The 12-step process follows six core principles: (1) admitting loss of control and powerlessness over a behavior; (2) seeking support from a Higher Power; (3) seeking the help of a sponsor (experienced member) to help examine past errors and resentments; (4) making amends for these; (5) willingness and motivation to live a sober life governed by a new code of behaviour; (6) willingness to help others who are suffering from the same problems you did.

Magura, Vogel and Knight (2000) have highlighted that involvement with Alcoholics Anonymous was not associated with any reduction in mental illness or increases in mental wellbeing; however, participation in Dual Recovery Anonymous (a group specifically for those with co-occurring disorders (a)) was associated with improvements in both (cited in: Drake *et al*., 2007). Similarly, American Treatment Improvement Protocol guidelines for those with co-occurring disorders (a) suggest that this population may be better served by group interventions specifically designed for those with co-occurring mental disorders (Sacks, Ries and Ziedonis, 2005). The authors state that stigma associated with mental illness may surface within meetings and result in service users feeling judged and losing trust in the group; they also suggest that 12-step groups may provide well-meant, but inappropriate advice regarding medication adherence. Furthermore, they state that groups specifically designed for those with co-occurring disorders (a) may well be more beneficial, as engagement with those with similar mental disorders will foster a sense of acceptance, belonging and hopefulness, as well as providing a space wherein participants can discuss their mental illness openly and honestly.

There is also evidence to suggest that traditional 12-step groups are inappropriate for those with experiences of trauma. In one study on women with co-occurring disorders (a) and histories of trauma, Harris and Fallot (2001) noted that certain elements of the 12-step approach may be damaging to this client group. They suggest that the completion of a 'moral inventory', required for 12-step progression, may push a woman to "assume responsibility that may not be hers" (p. 71). They also note that techniques involving confrontation and shaming of past behaviour involved within these groups may resemble past abusive tactics resulting in re-traumatisation. Finally, they suggest that the requirement to rely on a Higher Power to fix one's defective character may prevent women from acknowledging their own personal power. Past experience of trauma is common among service users accessing substance use services, especially for women (Sacks, Ries and Ziedonis, 2005) and trauma is often intrinsically related to an individual's substance use as it serves as a rationale for self-medication and thought suppression (Marcel *et al*., 2016). Therefore, this group may benefit from specifically designed group interventions. Fallot and Harris (2002) developed the Trauma Recovery and Empowerment Model (TREM) to address this. This gender-specific group intervention encourages interaction with those with similar experiences but is crucially non-confrontational. It helps to build self-esteem, improve emotional regulation and address

symptoms of anxiety and depression, which are often a result of trauma. It also encourages women to understand the interconnected relationship between their substance use and trauma.

In summary, it seems that group interventions are best served when those involved all have similar lived experiences. While 12-step groups are undoubtedly beneficial for those with substance use problems, those with co-occurring disorders (a) or histories of trauma may benefit from groups which revolve around their own lived experiences. Indeed, this was highlighted by Mueser, Drake Sigmon and Brunette (2008) who found that group interventions which have been specifically designed for those with co-occurring disorders (a), such as those based on CBT principles, have been shown to be more effective than standard 12-step approaches.

Peer Mentors

Peer mentoring is a popular treatment approach within the substance use field. It describes a method whereby an individual further along the recovery process becomes a mentor to those in the earlier stages of treatment and recovery. Evidence suggests that peer recovery interventions, such as peer mentoring, are associated with "reduced relapse rates, increased retention in treatment, better relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience" (Strang *et al*., 2017: 79). In the same vein as group therapy, the strength of peer mentors lies in their ability to empathise with service users from their own personal experiences. The Surgeon General's report on substance use in America noted that engaging with peers who have completed recovery, and who are able to share their own lived experiences, helps service users to sustain their own recovery (Murthy *et al*., 2016).

Peer mentors are also a valuable source of hope for service users (Maguire, Holloway and Bennett, 2014; Christie, 2017), which has been described as a core element of successful treatment and recovery for substance use problems (Davidson *et al*., 2013; Christie, 2017). Through their lived experiences, mentors also provide an element of relatability to service users. As one participant noted in a recent study on peer mentoring in Wales (Maguire, Holloway and Bennett, 2014: 68):

> "…they understand where you have been; what you are going through and how hard it is to overcome that addiction. And they understand every step of the way."

Research has also suggested that peer mentoring is as beneficial, if not more so, for the peer mentors themselves (Maguire, Holloway and Bennett, 2014) as it can help the mentor realise and focus on their strengths (Strang *et al*., 2017). In a longitudinal study into the efficacy of the Peer Mentor program in Wales, Maguire, Holloway and Bennet (2014) found that becoming a peer mentor helped build confidence and self-efficacy, and led to improved employment prospects. Furthermore, a number of participants described how valuable they felt when they were able to help other vulnerable people. This observation supports the 'wounded healer' hypothesis, which posits that those who have experienced pain and trauma often seek to help those with similar experiences to their own (Kirkcaldy, 2013). However, whilst the majority of participants achieved positive outcomes during the study, only 10% had entered employment by the end of the study and only 14% had gained a qualification. Furthermore, those who had gained employment were predominantly participants who had previous work experience or qualifications. This suggests that substance use services would benefit from improving the employment prospects of service users through vocational training, especially if they have little to no experience of work. Nevertheless, the study noted the "overwhelmingly positive" reaction from service users who were recipients of peer mentoring. They noted that guidance from someone with similar experiences, who had overcome similar problems, promoted a sense of optimism among service users regarding their future. However, the authors noted that the lack of aftercare involved in the project (due to funding regulations) was problematic for some participants who, after doing well on the course, relapsed once they entered employment. This suggests, as the authors note, that service users need continual support once they gain employment, as this can be a stressful period, and stress is a significant predictor of relapse (Sinha, 2008).

Cognitive Behavioural Therapy

There is strong empirical evidence that Cognitive Behavioural Therapy (CBT) is useful for treating a number of disorders (McMain, Newman, Segal and DeRubies, 2015), and it is a popular method of treatment for anxiety, depression (Whitfield and Davidson, 2008; McMain

et al., 2015) and substance use (Davey, 2016). The role of CBT in substance use treatment surrounds helping clients to become more aware of the relationship between their thoughts, mood and substance use, and helping them develop new skills to cope more effectively with their problems (Petersen and McBride, 2002; Sacks, Ries and Ziedonis, 2005; McKay, 2017). It aims to encourage clients to identify any distorted thinking that may underlie their substance use and to challenge these beliefs by weighing-up the available evidence so that they avoid using drugs to cope with their problems (Sacks, Ries and Ziedonis, 2005). During qualitative interviews with female trauma survivors with co-occurring disorders (a), some participants highlighted that the skills which CBT helped them develop were "essential" to sustaining recovery (Harris, Fallot and Berley, 2005: 1294).

Whilst some authors have recommended its use in the treatment of co-occurring disorders (a) (Sacks, Ries and Ziedonis, 2005), specifically co-occurring depression (Brown *et al*., 1997; cited in Flynn and Brown, 2008; Strang *et al*., 2017), others have suggested that it often proves no more effective than other psychological therapies for this group (Hides, Samet and Lubman, 2010; Marcel *et al*., 2016). Furthermore, the positive results also diminish over time, resulting in high relapse rates (cited in: Chiesa and Serretti, 2014). Ross and colleagues (2016) note that CBT is time-consuming and needs to be implemented by highly trained staff who are not always available within drug treatment services. The authors also suggest that CBT is complex and participants require a certain level of intellect to grasp it; this may make it inappropriate in the treatment of substance use disorders, given the poor educational levels and cognitive defects associated with those with substance use disorders.

Behavioural Activation

Some evidence suggests that an underlying factor between depression and substance use is a lack of positive reinforcement from an individual's environment (Van Etten, Higgins, Budney and Badger, 1998, as cited in: Magidson, Gorka, MacPherson, Hopko, Blanco, Lejuez and Daughters, 2011). Behavioural Activation therapy derives from the 'behavioural' aspect of Cognitive Therapy and attempts to address these problems through engagement in meaningful activity (Jacobson *et al*., 2001). Behavioural Activation challenges the notion that mood changes need to occur before behaviour change and encourages an experimental

approach by participants, whereby they try engaging in an activity to see if it improves their functionality over time; if it does not, then it is discontinued (Jacobson *et al*., 2001).

Behavioural Activation has shown some promise in treating co-occurring substance use and depression (Strang *et al*., 2017), and some studies have found it to be superior to combined CBT and anti-depressant medication (Ross *et al*., 2016), with the added benefit that it does not require such highly experienced therapists, since it is less complex and time consuming to implement (Marcel *et al*., 2016). However, in a recent literature review, Martinez-Vispo and colleagues (2018) found that while Behavioural Activation showed promise in treating co-occurring depression and substance use, the results were mixed. While some participants reported moderate improvements in depression and decreases in substance use, many showed no improvements that were statistically significant. Nevertheless, the most methodologically sound study in the review did find a statistically significant reduction in substance use. This suggests that while methodologically rigorous studies into the effectiveness of Behavioural Activation for clients with co-occurring depression and substance use are scant, results are promising.

Behavioural Activation can also incorporate elements of physical activity, which provides an array of health benefits (Neale, Nettleton and Pickering, 2012) and represents a low-cost, effective method of treatment for anxiety and depression (Marcel *et al*., 2016). Recent research has suggested that physical exercise may be as beneficial in treating depression as psychotherapy and antidepressant medication (Hidaka, 2012; Marcel *et al*., 2016), and there is “strong evidence” for its use in the treatment of substance use disorders (Wang *et al*., 2014). After a meta-analysis involving 22 studies, Wang and colleagues (2014) found that while results were stronger for illicit drug users, studies showed that physical exercise, regardless of its intensity, improved abstinence rates and helped in the withdrawal from illicit drugs, alcohol and nicotine; as well as improving symptoms of anxiety and depression. This suggests it may provide an effective treatment modality for those with co-occurring disorders (a). Indeed this was highlighted in previous qualitative research on heroin users, which found that service users derived great enjoyment through engaging in physical activity and sport during treatment and recovery, and attributed this exercise to a range of health and social improvements, including a reduction in their heroin use and symptoms of

stress, anxiety and depression (Neale, Nettleton and Pickering, 2012: 123). As the following quotes highlight:

> "I exercise much more now and I find that really helps with stress and depression, just helps me feel more alive I suppose."

> "I think when I'm feeling quite anxious and stuff, if I go and have a good workout it might help me, for a bit, you know. Let off a bit of steam, a bit of tension."

Physical exercise helped sustain recovery by expanding social networks, taking their mind off of drugs, alleviating boredom and occupying their free time (Neale, Nettleton and Pickering, 2012). However, given the myriad of health problems associated with co-occurring disorders (a) (Torrens *et al*., 2015), physical exercise may not be appropriate or appealing for some service users (Neale, Nettleton and Pickering, 2012: 124).

Mindfulness-Based Interventions

Mindfulness-based interventions are described as 'third wave' Cognitive Behavioural Therapies (Hayes and Hofmann, 2017). They differ from conventional CBT by attempting to redefine how an individual interacts with their thought processes, rather than attempting to change the thoughts themselves (Teasdale *et al*., 2000; Marlatt, 2002). It aims to achieve this by teaching clients to perceive their thoughts in a more detached manner, viewing them as a passing mental occurrence rather than an accurate depiction of reality (Teasdale, 1988; Teasdale, Segal and Williams, 1995, as cited in Davey, 2016). By improving awareness of the thought processes in a detached, unreactive way, the aim is to prevent over-identification with thoughts, and the automatic and habitual behaviour that often accompanies them (Marlatt, 2002). For example, in one qualitative study, participants mentioned that cultivating a sense of mindfulness was important in supporting them to sustain abstinence, as it helped them become more vigilant and pay more attention to their emotional states (Harris, Fallot and Berley, 2005).

After a literature review on the efficacy of mindfulness-based interventions, Chiesa and Serretti (2014) highlighted that although many of the reviewed studies suffered from a

number of methodological limitations, including small sample sizes, lack of randomisation and lack of information to ascertain treatment adherence, mindfulness-based interventions offer a promising new approach to the treatment of substance misuse. A more recent meta-analysis, which included a significant number of randomly controlled trials, found that mindfulness treatment had a small but significant effect reducing substance misuse, and a large significant effect on reducing levels of stress (Li *et al*., 2017). As stress is likely to induce craving (Davis *et al*., 2018) and increase vulnerability to substance use problems (Sinha, 2008), it is curious that this study highlighted only a small effect on substance use but a large effect on stress-reduction, given that the two seem intrinsically linked. One could argue that although mindfulness can be an effective method of treating substance use problems, treatment still needs to be multi-dimensional (Craig *et al.*, 2009). Therefore, combining mindfulness with other treatment interventions such as peer mentoring or Behavioural Activation, may improve the effectiveness of mindfulness treatment.

Mindfulness-based therapies may have "general applicability" through addressing "processes that occur in multiple disorders by changing a range of emotional and evaluative dimensions that underlie general aspects of wellbeing" (Hofmann, Sawyer, Witt and Oh, 2010: 10). As such, mindfulness techniques may be especially beneficial to those with co-occurring disorders (c) by targeting the underlying psychological and physiological processes associated with anxiety and depression (Garland and Howard, 2013a, as cited in: Garland *et al*., 2016), such as rumination (Brewer, Bowen, Smith, Marlatt and Potenza, 2010; Li *et al*., 2017; Davis *et al*., 2018) and stress (Weinstein, Brown and Ryan, 2008; Davey, 2016; Li *et al*., 2017; Davis *et al*., 2018).

The method does have limitations however, as it requires sustained commitment and perseverance, which make it a somewhat challenging treatment approach given its necessity for the active and constantly willing participation of the service user, especially outside treatment hours. The amount of time spent practising mindfulness between sessions was associated significantly with treatment success (Li *et al*., 2017); poor commitment to the approach outside formal treatment was associated with increased substance use and likelihood of relapse (Brewer *et al*., 2010). It may also be the case that commitment to mindfulness practice outside treatment hours may be more associated with a motivation to

change than meditative quality (Marcus *et al*., 2009). Furthermore, recent studies have shown that those with co-occurring disorders (c) are less likely to use mindfulness skills (Bradizza *et al*., 2018), which represents a hurdle for treatment among this group.

Wellbeing Models

Improving wellbeing has been shown to play an essential part in the recovery process (Best and Laudet, 2010; Best, Savic, Beckwith, Honor, Karpusheff, and Lubman, 2013; Best, Edwards, Mama-Rudd, Cano and Lehman, 2016; Cano, Best, Edwards and Lehman, 2017; Collinson and Best, 2019), and is an entwined component of almost all treatment interventions. For example, social support networks may act as buffers to mitigate the harmful effects of perceived stressors and in doing so, improve mental wellbeing (Thoits, 2011), which can facilitate the building of further support networks (Frederickson, 1998; cited in: Veenhoven, 2008). Indeed, UK Drug Strategy highlights wellbeing as one of the "three overarching principles of recovery" alongside citizenship and freedom from dependence on substances (Home Office, 2010: 18; cited in Best *et al*., 2013).

Wellbeing therapies focus on current problems and psychological states through an individualised approach that emphasises self-observation as a tool to develop the skills necessary to sustain positive emotional states. A structured diary is used to record instances of wellbeing to encourage individuals to become more aware and recognise positive emotional states when they occur (Fava and Tomba, 2009), a technique similar to the present moment focus and savouring within mindfulness therapies. Once a repository of factors that promote wellbeing have been observed and recorded, individuals are prompted to begin to identify particular thought-patterns that precede negative emotional states, so erroneous thinking and alternate interpretations can be discussed; a technique that follows a similar vein to CBT.

Expanding on Ryff's (1989) seminal wellbeing model, Ryff and Keyes (1995) outlined six core principles of psychological wellbeing: (1) *Self-acceptance* – feeling positive about oneself and past life, acknowledging and accepting both good and bad qualities; (2) *Personal growth* – being open to new experiences and perceiving and recognizing themselves in a

continued state of development; (3) *Purpose in life* – believing life has meaning and holds a sense of directedness with aims and objectives to achieve this; (4) *Environmental Mastery* – making effective use of opportunities and maintaining a sense of competence in managing external factors in their environment; (5) *Autonomy* – being independent and able to resist social pressures to think or act in certain ways; (6) *Positive relationships with others* – being able to develop and maintain satisfying and trusting relationships with others. Fava and Tomba (2009) argue that given the high remission rates associated with the use of CBT treatment for anxiety and depression, wellbeing therapies may be better equipped to address these unsatisfactory relapse rates and more effective in maintaining positive affect in the long-term, especially when combined with CBT and mindfulness principles (i.e. seeing oneself as the observer of intruding thoughts).

In light of the adverse consequences associated with poor wellbeing such as increased anxiety and depression (Fava and Tomba, 2009) it seems relevant to highlight contemporary and prominent pieces of Welsh legislation regarding wellbeing, specifically the Social Services and Well-being Act (2014)[17] and the Well-being of Future Generations (Wales) Act (2015)[18]. Both pieces of legislation aim to improve wellbeing by taking a preventative approach to problem solving, in the hope that this will help reduce future adversity and the negative consequences it has on society. For example, a recent report by the Future Generations Commissioner set up by the Well-Being of Future Generations (Wales) Act (2015) noted that there was a general "lack of consideration of the wider determinants of poor mental health"

[17] The Social Services and Well-being Act (2014) aims to Improve and increase preventative services within communities to help redress adversity before it exacerbates, and improve the wellbeing of individuals who need care and support, as well as carers who also need support. It also promotes collaboration between government departments, partner organisations and health services, and strives to improve provisions for involving individuals in the design and delivery of services, giving them more control over attaining outcomes that improve their wellbeing.

[18] The Well-being of Future Generations (Wales) Act (2015) places a duty on public bodies to ensure that decisions are made based in the principle of 'sustainable development', namely, acting in a manner which "seeks to ensure that the needs of the prevent are met without compromising the ability of future generations to meet their own needs" (p. 5). Essentially, the Act complies public bodies to consider how decisions made today will impact upon future generations in Wales in order to take a more preventative approach to problem solving. It also ensures that organisations are taking a collaborative approach to problem solving and decision making, using Public Service Boards to incorporate a multi-agency approach, involving stake-holders in the decision-making process.

such as “access to opportunities, access to and use of green space, and wider family and societal influences” (Future Generations Commission for Wales, 2017: 20). The report states that developing a more detailed picture of people’s lived experience was important in improving our understanding of what supports good mental wellbeing through increased collection of qualitative data – given the association between recovery and improved mental wellbeing, this research will hopefully go some way to address this gap.

Recovery Capital

The concept of Recovery Capital was developed by Cloud and Granfield (2008: 1972) who defined it as: “The sum of one’s resources that can be brought to bear on the initiation and maintenance of substance use cessation”. In essence, recovery capital pertains to the acquisition of both internal and external supports that can be drawn upon to help sustain an individual’s pathway toward recovery. The Recovery Capital model is comprised of four fundamental components: s*ocial capital* (i.e. support acquired from familial and friend relationships, as well as support from groups); *physical capital* (i.e. tangible assets such as financial stability, and adequate housing); *human capital* (i.e. good physical and mental health, and coping skills to help individuals prosper); and *cultural capital* (i.e. values, beliefs and attitudes that allow an individual to conform to socially acceptable behaviours). Although, Collinson and Best (2019) argue that cultural capital lies within the broader domain of community or collective capital. This capital refers to community resources such as transport links, available pro-social activities, groups and facilities, recovery communities and the presence of non-stigmatising attitudes within the community. Additionally, Neale, Nettleton and Pickering (2014) argued that health capital should be introduced as the fifth domain of recovery capital and that human capital should be expanded to include a variety of life skills such as budgeting, cooking and cleaning.

Recovery capital has developed as an effective method of measuring recovery (Collinson and Best, 2019) and is associated with improved levels of wellbeing (Cano, Best, Edwards and Lehman, 2017). A recent systematic review of the Recovery Capital literature (Hennessy, 2017) highlighted five principle elements consistent across the studies involved: 1) Recovery is an ongoing process and Recovery Capital is dynamic and exists on a scale, with

a variety of opportunities to progress both up and down; 2) Individuals progress continuously along this scale and can possess different levels of Recovery Capital dependent on a variety of interacting factors; 3) Recovery Capital is dynamic and self-perpetuating, meaning that advancements in one area often lead to advancements in others; 4) Recovery Capital is comprised of a multitude of resources and should be considered as a whole; 5) An individual's socioeconomic status often directly translates to the amount of Recovery Capital they possess. The review also noted that financial (an aspect of physical capital), human and social capital were consistently identified as the most prominent and important domains in the responses of participants of the qualitative studies involved.

Cano, Best, Edwards and Lehman (2017) argue that services should focus on building recovery capital through developing opportunities to partake in meaningful activities such as employment, volunteering, education and community engagement, as these areas empower individuals and help facilitate the building of new skill-sets and resources necessary for recovery. Developments in these areas also lead to improvements in self-efficacy and self-esteem, both of which play a valuable role in the recovery process.

Conclusion

In conclusion, despite their prevalence, co-occurring disorders (a & c) still remain understudied, misunderstood (Lai *et al*., 2015; Motta-Ochoa *et al*., 2017) and there remains no consensus on the most appropriate treatment methods for this group (Torrens *et al*., 2015). As Torrens and colleagues (2015: 9) note:

> "It remains important to study the occurrence of psychiatric comorbidity in drug users, both to determine its magnitude and to help improve the coverage of adequate treatment."

The vast majority of the research conducted on the topic of co-occurring disorders (a) has also been undertaken in America. Indeed, American research has comprised the vast majority of this review. This may affect its generalisability to the UK and therefore more UK-based

research on the topic needs to be undertaken, particularly research projects with a focus on specific disorders in order to improve treatment interventions (Flynn and Brown, 2008).

NICE emphasises the importance of engaging those experiencing treatment in the research and the design of new treatment interventions (NICE, 2016), yet research on substance use treatment often employs a quantitative approach from the stance of the service provider, rather than qualitative one from the perspective of the service user (Neale, Nettleton and Pickering, 2013). This approach restricts exploration into new ways of thinking and removes the voice from those experiencing the topic of research for themselves.

To date, to the author's knowledge, there have been no qualitative studies conducted in the UK which aim to engage directly with service users with co-occurring disorders (c) to better understand their recovery experience. Therefore, the current research will adopt a qualitative approach to provide service users the opportunity to discuss their treatment and recovery process, highlighting any areas they feel are beneficial or frustrating, in the hope of using their insight to improve treatment production. Given the frequency with which anxiety and depression co-occur with substance use problems, the specificity provided by this research will hopefully go some way to improve the treatment prospects of this group and improve our understanding of how and why these mental illnesses co-occur with substance use problems, so that we are better equipped to prevent such disorders coalescing in the first place (as cited in: Lai, Clearly, Sitharthan and Hunt, 2015). Therefore, this research will also include a life history element to ascertain what factors may facilitate drug use and what factors may enable or impede the recovery process.

Chapter Two: Methodology

This chapter details the methodological approach adopted for this research project. To begin, a brief overview of the Welsh Centre for Action on Dependency and Addiction (WCADA) will be provided, which is where this research was conducted. This will include the services they provide and what services will be the focus of this research. Following this, the chapter will discuss the research questions, their links with the literature and the rationale for adopting a qualitative methodological approach. Thereafter, the methods used to conduct this qualitative research will be discussed; namely, participant observation and semi-structured interviews, and why they are appropriate for this type of research. The chapter will then discuss the data analysis process, and the importance of ethical consideration throughout the research project. Finally, the chapter concludes with some reflections on the research process.

The Welsh Centre for Action on Dependency and Addiction (WCADA)

This research project was conducted in conjunction with WCADA[19], which has been providing substance use treatment for almost 40 years. WCADA is a substance misuse charity based in Swansea and although this research was conducted predominantly with the Swansea treatment centre, WCADA also has offices in Neath, Port Talbot and Bridgend. However, the only engagement this research had with the other treatment centres[20] was through the DOMINO project, which, due to budget constraints, runs as a single project across each location.

WCADA was chosen for this research project due to their involvement with service users who suffer from co-occurring disorders (a), the treatment interventions they offer for this population and their willingness to participate in this research. Additionally, given the

[19] It should be noted that WCADA also invested financially in this research, alongside a European Social Fund grant. However, while the research topic was defined through mutual agreement, I was given full autonomy in the approach, design and direction of the research and WCADA made no attempt to involve themselves in this process.

[20] I also met with some staff from the Neath office regarding the SWITCH project, however, engagement with this program was not pursued given the younger ages of service users engaged with it

constraints of the limited resources available during an MPhil project, WCADA were also geographically accessible. Geographic accessibility was also one of the principle reasons for focusing predominantly on the Swansea centre, along with this site being the largest and the location of organisation's headquarters.

WCADA provides treatment for substance-misuse problems, as well as opportunities to learn new skills and improve employment perspectives. Many of the services are run by peer mentors who are able to provide expert opinion from personal experience. Their services include crisis intervention, needle exchange, motivational interviewing, psychological one-to-one interviews, community support and outreach, pre and post detoxification/residential rehabilitation support, structured counselling, group work, relapse prevention, aftercare and referral to self-help groups. This project, however, will concentrate on the DOMINO, Cyfle Cymru[21] and Community Outreach services provided through WCADA, as these are the services most associated with service users suffering from co-occurring disorders (c). Below is a brief description of these services.

The DOMINO Project

The DOMINO project is focused on assisting service users to lead happier, healthier, more active lives, and provides opportunities for clients to fill their time constructively in a relaxed and supportive atmosphere. In addition to offering an alternative to any previous substance-oriented social life, it provides motivation, confidence building, and aids the development of essential social skills through its communal focus. It provides service users with opportunities such as cookery classes, music lessons and gardening, whilst placing significant emphasis on reconnection with nature, the outdoors, and other people, which research has shown to yield valuable therapeutic results (Hari, 2018). The therapeutic element at the core of the DOMINO project made it an attractive intervention to study for this research.

In regards to my involvement in this service, I identified as both researcher and peer. I made clear to all those I spoke with that the purpose of my involvement was as a researcher.

[21] Although Cyfle Cymru operate from WCADA premises, it is a separate service and is not run by staff on the WCADA payroll

However, I was careful not to portray myself as a passive observer of the treatment environment as I felt this would have created an obstacle in data collection (a point that is expanded upon later in the chapter) and as such, I actively engaged in the activities offered. It is in this sense that I identified as both a peer and a researcher.

Cyfle Cymru

This peer mentoring service focuses on both mental health and substance use, providing peer mentoring to help service users improve key skills and find employment. The service also offers paid mentoring roles to those who have completed treatment. The service's focus on the co-occurring disorders (a) and their role in training peer mentors made this service a particular interest to this project.

The service offers a range of programmes, such as 'Personal Development' – a psychosocial group run by a peer mentor, wherein service users discuss various emotional and mental health problems (i.e. anxiety/anger/stress), topics relating specifically to substance use (i.e. dealing with craving/ relapse prevention) as well as providing space to discuss aspects of mental illness (coping with anxiety and depression were frequent topics of discussion). The service also offers 'Job Club', wherein service users are provided access to computers and the support of staff to search and apply for jobs, or to complete a variety of online qualifications to help bolster their employment prospects.

My involvement in this service was similar to my involvement with the DOMINO Project, as described above – in part as some of their services overlap. However, where they did not – for example, in regards to the Personal Development psychosocial group, I took on a similar researcher/peer role. While I was there primarily to research the programme, how it functioned and how service users engaged with it, I also actively engaged with the group and was open to discussing my own experiences with whatever topic was on hand.

Community Outreach Service[22]

This service enables staff to visit the homes of service users referred to WCADA by various organisations. Initial assessments are conducted in the homes of clients with the hope of eventually encouraging them to begin frequenting the treatment centre. This service is especially beneficial to those with severe anxiety and depressive disorders as it provides an initial, supported stepping-stone toward treatment in the comfortable setting of their own home. Community Outreach also provides assistance and support for various other aspects of a service user's life, including doctors and dentist appointments, helping with benefits, and liaises heavily with Social Services to provide the most effective support. Its involvement with individuals with anxiety and depression made this a service of interest for this project.

Unlike the two other services, my involvement in this service was purely as a researcher. As this was an outreach service, wherein staff meet with service users who are yet to formally engage with substance use treatment, there was no space to identify as a peer. On home visits, I shadowed WCADA and Social Services staff and introduced myself as a student working with WCADA to better understand the recovery experience of those with co-occurring disorders (c).

Research Questions

The literature highlighted that those with co-occurring disorders (a) suffer poorer treatment outcomes (Torrens *et al*., 2015; Christie, 2017; Strang *et al*., 2017) and that anxiety and depression are the most common disorders to co-occur with substance use problems (Lai *et al*., 2015). The relationship between anxiety, depression and substance use, however, is still poorly understood and further research is required to study the relationship in order to provide more effective treatment interventions (Lai *et al*., 2015). As the majority of the research on the subject derives from the US, there remains a gap in approaching the treatment experiences of service users from a UK perspective. Additionally, there is also a lack of research which focuses on specific disorders (Flynn and Brown, 2008). Therefore, this

[22] This service was used for participant observation only. As the service users I encountered during my time with this service were described by staff as 'especially vulnerable', I did not believe it was appropriate or ethical to approach them for interview.

project aimed to engage with service users suffering from co-occurring disorders (c) within their treatment setting in order to seek their insight and perspective on their recovery process. In addition, this research also aimed to provide service users with an opportunity to evaluate their treatment and identify any aspects they value or would like to see improved.

Denzin (1989) states that the value of 'how' over 'why' questions during qualitative research should not be overstated when attempting to understand complex social issues. Given the inherent complexity of mental illness and substance misuse, the research question adopted for this project followed this advice:

How is recovery experienced and understood by those with co-occurring anxiety and depression?

To address this question, the following themes were explored using qualitative methodology:

1. What are service users' experiences of the treatment process?
    a. What factors do service users' believe facilitated their drug use?
    b. What barriers to recovery do service users' experience?
    c. What do service users' value from treatment?

2. A life history element was also incorporated to provide a contextual basis for the data collected

This section of the thesis details the research process within WCADA and the reasoning behind the data collection methods employed during this project. The research aimed to explore the themes raised through the literature review using the qualitative methods discussed below; namely, participant observation and semi-structured interviewing.

A Qualitative Methodological Approach

In contrast to the positivist paradigm popular within natural sciences, social science research often favours a naturalistic paradigm. Many critics argue that purely objective research is limited in the realm of social science as the research always takes place within a social context and is therefore open to be interpreted through the lens of a participant's subjective experiences (Cairns and Nicholls, 2018). Objective social reality is considered to be unrealistic given that human actors constantly project their own meaning and purpose onto their lives and its encompassed events (Guba and Lincoln, 1994). Guba and Lincoln (1994) argue that there is no objective reality to observe in social science and instead adopt a relativist view, that our social world is subjective and no research will ever be able to provide an absolute truth. In essence, human behaviour is complex and multi-faceted and therefore requires a different methodological approach to those used in the natural sciences (Armstrong, 2010). Instead, by engaging in discussion with those we seek to study, participants' subjective truth may be uncovered and interpreted. This interpretive approach allows researchers to gain a deep, contextual understanding of the problem in question through eliciting rich data sets filled with nuance and complexity.

Interpretivism is sometimes critiqued for being overtly subjective and inevitably imprinting the authors own interpretations and biases onto the research. Subjectivity, however, is a key part of the research process within qualitative paradigms and this process represents a fundamental feature in the creation of knowledge (Flick, 2014). Although it is true that the inclusion of information that a researcher deems significant (and therefore given validation through their biases) is difficult not to infer onto research (Bryman, 2016), these theoretically-based biases are in fact a fundamental part of the creation of knowledge within interpretive research (Denzin, 1989). Given the preliminary research that this project undertook in the form of a literature review, an objective, value-free perspective was unrealistic. As with many other interpretive approaches to social research, I maintain that beliefs founded in theoretical evidence are impossible to completely remove from inquiry. Instead, they are in fact fundamental to the research process. By combining theoretical knowledge with the experiential expertise of participants, patterns emerge and conclusions

can be drawn. Similar to Hammersley (1992a), I believe that a researcher is always involved in the creation of knowledge, as opposed to simply extracting (cited in: Bryman, 2016).

Within social science research, it is often the case that "the greater the distance between direct experience and its interpretation, then the more likely resulting knowledge is to be inaccurate, unreliable and distorted" (Beresford, 2003; cited in: Cairns and Nicholls, 2018: 1). Therefore, engaging directly with participants during participant observation and interview to ascertain their complex lived experience allows the researcher to most accurately represent their views and experiences. This is especially relevant within substance use research, as the experiential knowledge of service users can provide the "essential insight" necessary to improve treatment and recovery prospects (Cairns and Nicholls, 2018: 1). This participatory approach of engaging in genuine dialogue with service users, with an emphasis on mutual trust and respect, has particular value when attempting to understand the lived experience of marginalised or vulnerable groups, such as those engaged with the mental health or substance use services (Livingston and Perkins, 2018).

This 'co-production' of research or a 'bottom-up' approach is increasingly popular within health research, and involves engaging service users in the research process to gain their insight on their treatment experience. It has proved invaluable to improving the quality, efficiency and relevance of future research and treatment provision (Cairs and Nicholls, 2018) and, as Livingston and Perkins (2018: 69) state: "it is just the right thing to do". Although this research project did not engage in full co-production, or participatory action research (directly involving service users in all aspects of the research process: design, analysis and write-up), similarly to Wilkinson and Wilkinson (2018: 6), this research involved "pockets of co-production". That is, while participants were not involved in the design, analysis or write-up of the research, they were "active participants in, rather than passive subjects of", the research (Lowes and Hulatt, 2005; cited in: Cairns and Nicholls, 2018: 3). Service users were given the opportunity to participate in interviews and discuss their experiences with me during participant observation, if they wished to. Although I actively engaged in participant observation, their involvement and whether or not they shared their experiences with me was entirely on their terms. Participant observation and the interview process are discussed in more depth later in the chapter.

The qualitative paradigm, often used to research topics of which little is known (Armstrong, 2010), therefore offered this study a "flavour" of the recovery process of service users (Harris, Fallot and Berley, 2005: 1296). It provided the opportunity to gather rich, nuanced and contextualised data, regarding how service users experience co-occurring disorders (c) and their treatment and recovery (Punch, 2014; Simpson, Conniff, Faber and Semmelhack, 2018). Moreover, as this research aimed to develop a better understanding of the relatively under-researched area of co-occurring anxious and depressive disorders, the qualitative paradigm offered a tool to gain valuable insight into the lives and behaviour of participants (Armstrong, 2010), which can be used as a basis for further quantitative studies (Krueger, 1994; cited in: Bradizza and Stasiewicz, 2003).

There is a strong case for qualitative methodology in social science (Brinkmann and Kvale, 2015), especially with studies concerning vulnerable populations (Denzin 1989; Renzetti and Lee, 1993; Liamputtong, 2007; Matthews and Ross, 2010; Cairns and Nicholls, 2018). Its ability to humanise research and the participants that encompass it provides a rich and nuanced data set, and thus helps elicit a deeper level of understanding of the problem in question. Reducing data to pure statistics risks losing the human element of research, arguably the most important element of social science research. Therefore, for this research, the voices and insight of those experiencing the problem in question for themselves was of paramount importance to improving their treatment.

Liamputtong (2007) advocates for the use of qualitative methodology when researching vulnerable populations, arguing that the close contact with participants which qualitative methodology embraces is especially useful when researching vulnerable subjects. Weibel (1990) also argues for the use of qualitative methodology when researching substance misusers specifically, stating that "qualitative research is often the only appropriate means available for gathering sensitive and valid data from otherwise elusive populations of substance abusers" (cited in: Liamputtong, 2007: 8).

In social research, particularly on marginalised and vulnerable groups, it is important to question who the "expert" really is (Livingston and Perkins, 2018: 69). Is it the researcher with a wealth of academic knowledge, or the service users with a wealth of lived experience?

This question is at the forefront of emerging research methodologies that seek to increase the participation of the subjects of research in the research process, to move toward research that places focus on studies "with and for, rather than on" its participants (Gilbert, 2008; cited in: Livingston and Perkins, 2018: 62). As Cairs and Nicholls (2018: 4) question: "who, in seeking to use research to develop better interventions, would not want to work as closely as possible with those to whom those interventions are directed?".

In their guidelines for treating those with co-occurring disorders (a), the National Institute for Health and Care Excellence (2016) emphasise the importance of involving those experiencing treatment in future research, and the design and delivery of new services so that it may be improved. This sentiment is further highlighted in the Welsh Government's (2016) 2016-19 delivery plan for improving mental health across Wales, and in their final report regarding the national 'Working Together to Reduce Harm' 10-year strategy (Welsh Government, 2018). Therefore, as this research aimed to gain first-hand accounts from service users with co-occurring disorders (c) who are experiencing the treatment process, a qualitative methodological approach seemed best suited to achieve this.

This project adopted a qualitative approach over a quantitative one for five main reasons: (1) to help facilitate the establishment of trust between research and participant, (2) to gain a more nuanced understanding of the problem in question, (3) to acknowledge the sensitivity of the research questions, (4) as a result of the vulnerability of the participant group, and (5) to acknowledge and capitalise on the experiential expertise of service users.

Methods

To explore the research question within WCADA, this project used two prominent research methods associated with qualitative research: participant observation and semi-structured interviewing (Matthews and Ross 2010; Flick, 2014; Punch, 2014; Bryman, 2016).

Participant Observation

The first data collection technique of this project is ethnographic participant observation. Specifically, unstructured participant observation (Punch, 2014) of the Cyfle Cymru, DOMINO and Community Outreach services. The notion of non-participant observation was discarded as building trustful relationships with clients was essential, and taking a backseat, observer role would likely have sown distrust between myself and the service users. Without trust, any subsequent interviews would suffer, given the sensitivity of the research topic.

Ethnography entails the researcher "participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, [and] asking questions" (Hammersley and Atkinson, 1995: cited in: Holliday, 2007: 18). While this research was not covert in any way, this method allowed me to become a "regular, intimate, but unobtrusive participant" in the day-to-day lives of service users (Alverson, Alverson and Drake, 2001: 4). Similar to Alverson, Alverson and Drake (2001), regular participation in the daily treatment experience of service users provided the opportunity to engage in "observation, conversation and informal interviewing" (p. 4) with service users, in an environment familiar to them. This helped facilitate a relaxed atmosphere and the development of the trustful relationships necessary to engage effectively with this group. The development of positive relationships is a valuable and necessary process for later qualitative data collection from vulnerable participants (Denzin, 1989; Renzetti and Lee, 1993; Liampottong, 2007; Punch, 2014; Bryman, 2016).

Whilst conducting participant observation, it was also important to keep a detailed field diary. This provided the opportunity to note interesting interactions, events or snippets of conversation that related to my research question, which could be analysed in more depth at the end of each day. These notes were made in as much detail as possible and then further expanded during a more appropriate time to include my own thoughts and reflections. As Bryman (2016) notes, carrying around a notepad and pen would likely have made service users and staff uncomfortable and self-conscious. Therefore, to be as unobtrusive as possible, I utilised the notepad on my smartphone to jot down any relevant information at appropriate times. This process meant that at the end of each day, these notes could be transferred to the more detailed field diary kept on my computer, along with any additional reflections.

The field diary and the events it detailed also helped develop research focus over the course of the study (Punch, 2014), and often acted as a "springboard for theoretical elaboration" (Bryman, 2016: 441). Many of the questions posed during the interviews were based on themes that emerged during interactions with service users and staff.

This data collection technique, coupled with subsequent interviews helped elicit the "thick description" necessary for qualitative methodology (Denzin, 1989; Alverson, Alverson and Drake, 2001; Geertz, 1973; cited in: Flick, 2014).

Sampling

Non-probability sampling was used to select participants from participant observation for interview. Non-probability sampling is a common method often used in qualitative research (Renzetti and Lee, 1993) given the interview style adopted (Matthews and Ross, 2010). As with much research that employs this method, it was chosen to select participants with the most suitable characteristics and experiences for the research topic (Matthews and Ross, 2010), namely service users and staff who suffer from anxiety and depression, who had also had some experience with mental health treatment. Their personal experience allowed the topic to be studied in depth, with both parties invested in the subject.

This sampling technique involved building relationships with service users, and then asking if they would be willing to participate in an interview. Additionally, given their personal experiences of the service users under their care, the advice of staff was also sought to help sample the most appropriate and informative service users; those who had the most to talk about and who were most willing to share their experiences. It also ensured that particularly vulnerable service users were excluded from the study. Moreover, given the limited time and resources of an MPhil project, and the small scale of interviews, this sampling technique also decreased the likelihood of the time-consuming obstacle of non-response[23] (although this was still encountered).

[23] "Non-response" refers to those service users who agreed to an interview but then withdrew their consent on the day, or did not show up

Nine participants (Male = 7, Female = 2) between the ages of 35 and 55[24] were recruited for interview and included both service users and peer mentors. Service users were sampled from the Cyfle Cymru and DOMINO services[25], as they helped address both substance use and mental illness. The aim was to understand their experience of the treatment process and what factors facilitate substance use from the perspective of service users and professionals working in the field, so that treatment may be improved for this population. However, although gender is examined in relation to traumatic histories being a facilitator of substance use, the gender imbalance of the sample meant that an in-depth exploration of a gendered dimension to my findings was beyond the scope of this thesis.

Some additional information for each interview participant is included in Appendix F, however, specific detail (such as detailed background information and exact ages) was excluded. Although this kind of information is commonly included in qualitative research, under the funding obligations of this research, a copy of this thesis will be provided to the organisation at which it was conducted. Therefore, I felt that given the small sample size, including too much information on each participant could threaten their anonymity and the confidentiality provided to their accounts.

Although this study is limited by the small number of participants selected for interview, qualitative research does not strive for statistically significant results. Its strength lies in nuance and in expanding knowledge through depth. Despite only nine participants, interviews lasted between one and two and a half hours (with an average length of one and a half hours), which provided an extensive amount of information for analysis and interpretation. The length of the interviews provided the opportunity to discuss a number of different subjects and for subjects that had not been considered to be discussed through the natural flow of conversation. Furthermore, the aim of this study was never to achieve statistical significance. Instead, the aim was to provide detailed accounts of service users'

[24] The exact age of participants was not disclosed within this research owning to the small sample size and the risk of anonymity being breached

[25] Sampling participants for interview from the Community Outreach Service was avoided due to the heightened vulnerability of individuals using this service. This is to say that as they had not yet engaged with treatment services and staff were attempting to persuade them to do so, therefore their problems with the topic of this research (namely, mental illness and substance use) were still extremely raw. As such, I felt it was inappropriate and unethical to approach them for interview.

perception and interpretation of the treatment they receive and the factors they believe influenced their use, and promoted or hindered their recovery. In this light, responses from interviewees may provide a foundation on which to base further research that could provide statistically significant results.

Due to the small sample size and lack of randomness regarding the selection of participants to interview, generalisability to a wider populous is considered implausible (Bryman, 2016). However, as various research has shown that most service users with co-occurring disorders (a) will encounter similar problems[26], collecting data to understand both their life experience and views on their treatment will always be useful, as they will often share similar experiences. Furthermore, Williams (2000) argues that often, interpretivism produces "*moderatum generalisations"* (p. 215). This is to say that some groups (e.g. drug users, an example explicitly used by Williams) may be seen as "instances of a broader set of recognizable features" (cited in: Bryman, 2016: 399). Through drawing comparisons with other research in the field with similar findings, generalisations can and should be made (Bryman, 2016). An idea similar to that of the 'universal singular' detailed by Denzin, whereby the experiences of a singular participant is subjective and unique to them but their experience also embodies the problems universal to individuals in similar situations. Connecting these personal troubles to the larger social context is the goal of interpretivism (Denzin, 1989).

This method of sampling for interview was not without limitations and it became clear that a secondary sampling technique would be useful in order to help gain the participants required. As a result of the limited resources available and the sensitivity of approaching service users to ask whether they suffered from a mental illness, volunteer sampling was also used to gain three interview participants. These were sampled from a psychosocial group intervention called Personal Development. This method sampled those service users who volunteered themselves to participate in this research after I had been formally introduced by the peer mentor at the beginning of the session and had explained who I was, and the nature of the research I was seeking to undertake. Service users who were interested in

[26] For example: poor financial situation, problems with housing, lack of employment, high rates of relapse and suicide, and difficulties navigating the treatment process (Strang *et al.*, 2017)

participating were encouraged to stay behind after the group where I would answer any questions they had and take their contact details to arrange a later interview.

Interviews

Semi-structured or 'in-depth' interviewing is a common technique utilised in qualitative research when discussing distressing topics with vulnerable populations (Renzetti and Lee, 1993; Liamputtong, 2007). It provides an intimate atmosphere proficient in eliciting rich, textured data from participants (Matthews and Ross, 2010) and are an invaluable tool for participant self-reflection (Brinkmann and Kvale, 2015). The approach has been used successfully during previous qualitative studies with service users suffering from co-occurring disorders (a) (Laudet, Magura, Vogel and Knight, 2004; Harris, Fallot and Berley, 2005; Motta-Ochoa et al., 2017). The interview approach involves a list of open-ended questions on fairly specific topics developed within an interview schedule (Bryman, 2016) but maintains the flexibility necessary for the interview to take on the form of a conversation (Brinkmann and Kvale, 2015). This grants the interviewee much greater leeway in how they respond to questions and the researcher much greater flexibility to probe deeper into responses that are deemed significant (Bryman, 2016).

Semi-structured interviewing offered the current research a first-hand view of the treatment process from the perspective of those receiving and delivering it. Through a range of open-ended questions aimed at engaging the interviewee in an informal, conversational-style interview, the intention was to provide service users the opportunity to reflect on and identify any aspects they found most beneficial or frustrating about their treatment and any barriers they feel placed the most strain on their recovery.

A professional opinion from those working in the field was also sought to discuss the problems they often encountered working with service users and which aspects of treatment they felt were particularly beneficial to those with co-occurring disorders (c). It also provided them with the same opportunity to praise or critique any aspect of the treatment process. Further, as the professionals discussed were peer mentors, they were able to discuss treatment from the perspective of both a service user and provider. Peer mentors all had histories of anxiety and depression before entering substance use treatment as service users,

and all had some experience of external mental health treatment. Although peer mentors had an assigned role within a service provided at WCADA, some services would sometimes overlap (e.g. DOMINO and Cyfle Cymru) and staff would cross services in this way.

Service users and peer mentors within WCADA were interviewed using the same qualitative, semi-structured interview technique. This again allowed the freedom to delve into and explore any pertinent responses, whilst the interview still maintained an informal, conversational tone. The hope was that the informality would allow the interviewee to feel more comfortable to talk openly about their recovery and treatment process, including any critiques they may have.

While much less structured than those used within standardised interviews, an interview guide is an important part of semi-structured interviews (Bryman, 2016). The interview schedule[27] in the current study was designed to reflect the research questions. It contained six broad topics, and a number of probing questions to help prompt interviewees to expand on their responses. Flexibility was the salient feature of the interview (Bryman, 2016). Participants were free to elaborate and digress as they pleased, as this allowed topics to emerge that had not been previously considered. However, if interviewees began to go too off-topic, they were encouraged to revisit the original question. This flexibility to go somewhat off topic in order to probe pertinent responses, helped develop questions for later interviews based on interesting themes that emerged during earlier interviews[28]. This resulted in a dynamic interview process and the opportunity for unconsidered avenues to be explored. As co-occurring disorders (c) are a relatively under-researched area, by giving participants the freedom to elaborate and digress, interesting and unexpected answers became more commonplace. This provided a space for unanticipated explanations and theories to emerge and be explored (Matthews and Ross, 2010).

[27] An example of the interview schedule used within this research can be found in appendix A

[28] For example, the important role treatment plays in providing a sense of structure to the days of service users, which helps them navigate their free time; or the negative effect that the financial restrictions of relying on benefits have on the mental health of participants and its exacerbatory effect on mental illness

The lack of rigidity, informal nature, and open-ended questions helped place interviewees at ease, as the session took the form of a conversation as opposed to a stereotypical interview. This conversational interaction helped facilitate the production of data from the participant (Matthews and Ross, 2010), whilst also incorporating the opportunity for mutual self-disclosure. As Denzin argues, "to listen only creates distrust" (Denzin, 1989: 43). Following Denzin's advice, I spoke openly about my own experiences with anxiety and depression in the hope that this would put participants at ease whilst discussing their own experiences. I believe this helped address the stigma associated with discussing mental illness, and facilitated conversation between myself and the interviewee. However, whilst being open to expanding on my own experience with anxiety and depression, it was important that I did not become the focus of the interview.

A challenge associated with semi-structured interviewing is the possibility of it being difficult to encourage participants in qualitative interviews to expand further on their answers (Bryman, 2016). This was somewhat addressed through the interview selection process and the building of trust; however, various prompts and probes were used to prompt participants to elaborate on their answers. A number of probing techniques to elicit more detailed responses from participants were utilised during the course of the interview process such as "what did you mean by that?" or "could you tell me more about that?". These simple questions proved useful methods of persuading interviewees to expand upon their answers. Another invaluable technique used to encourage participants to expand on their answers was simply using interpreting questions (Bryman, 2016). By summarising interviewee's answers, it ensured that I had understood their response and provided the opportunity for participants to confirm or challenge my understanding of their answer. This method proved especially useful as it both solidified my understanding of their response and often elicited more information by encouraging interviewees to better explain and expand on their point.

Interview Topics

The primary aim of this research was to understand the experiences of those in substance use treatment with co-occurring disorders (c); their opinions, in their own words, was paramount. However, although it was primarily concerned with how service users with co-occurring disorders (c) experience treatment, a life-history element was also important to consider to

provide some context. It also helped to highlight common elements that facilitate drug use or precipitate relapse and triangulate their experience with those articulated in the literature. Although this section was designed to be left to the end of the interview schedule as it was believed this would be the most sensitive topic, the life-histories of the interviewees became naturally interwoven into the conversation during various parts of the interview.

The interview schedule was split into two sections to explore six main themes. The first section concerned their treatment at WCADA, while the second concerned a life-history element that delved into their history of substance misuse and mental illness.

Section one – thoughts and feeling regarding treatment

1. Participants thoughts and feelings regarding the treatment received for their drug use at WCADA

This theme aimed at addressing how participants felt about the treatment they were receiving for their drug use at WCADA. It provided an opportunity to analyse their treatment and commend or critique any element they chose to. It also aimed to gather participants thoughts and feelings regarding whether or not they believed they had improved since treatment began and why they felt this way.

2. Participants' views on employment[29]

The second theme focused specifically on employment. Research has shown that individuals suffering from co-occurring disorders (a) are less likely to be employed than those with a 'pure' substance misuse problem (Torrens *et al*., 2015). As employment is linked with adverse mental health and increased risk of developing a substance use problem or mental illness (particularly anxious and depressive disorders) compared with employed persons

[29] The inclusion of this theme is not intended to dismiss the equally relevant domains of, for example, housing or education in the recovery experience of service users with co-occurring disorders (c). However, as this research engaged with the Cyfle Cymru service (a service specifically designed to improve the employment prospects of service users with mental health and substance use problems), it was a relevant theme to cover during interviews. Additionally, as the service also provided space to gain accredited qualifications, it also had an educational element

(Ishmuhametov and Palma, 2017), it was important to consider participants views on this topic.

The aim of this theme was to explore participants' views on employment, and the importance they placed on it. This theme also discussed the employment services offered at WCADA and whether participants found them useful.

3. Participants views on any improvements to their treatment

This theme provided the opportunity for participants to offer their own thoughts regarding how treatment may be improved for them, as little research has given service users themselves a voice to critique their treatment, or detail what they value from it. This theme did not relate specifically to substance use treatment, and included any external mental health treatment they had sought or received.

Section two – life history

4. Participants history of drug use, what facilitated it and any perceived barriers to their recovery

Theme four explored service users' history of drug use, when it began and what factors they believed facilitated it. The aim was to highlight factors that were associated with increased risk of developing a substance use problem and any barriers they faced in sustaining recovery. This helped to compare and contrast these factors with those highlighted in the literature.

5. Participants' experiences with mental illness and the respective treatment services

Theme five discussed mental illness and participants' experiences of it. Within this theme we also explored their experiences and expectations of any mental health treatment they have received and whether or not they found treatment services offered at WCADA to be beneficial to their mental illness. Similar to the previous theme, it also explored any barriers they encountered seeking support for their mental illness, as barriers in accessing treatment have

been highlighted as a key problem to both substance-misuse and mental health services (Hodges *et al.*, 2006).

6. Participants' feelings regarding the relationship between their mental illness and substance use, and the relationship between substance use services and mental. health services

Theme six covered co-occurring disorders (c) specifically, and aimed to look at why treatment outcomes for those with co-occurring disorders (a & c) are poorer than those without. Questions under this theme explored participants' thoughts and feelings on the relationship between their substance use and mental illness. It also explored the relationship between the substance use and mental health services.

7. A final section to close the interview explored participants' thoughts and feelings regarding their future

This theme was important for two reasons. Firstly, it provided the opportunity for service users to articulate their hope and desires for the future, which may be significant in sustaining recovery. However, perhaps more importantly, as many service users disclosed deeply personal and sometimes traumatic experiences, it ended the interview on a positive note.

The interview rarely, if ever, followed the exact layout set out within the interview schedule. The flow of conversation meant we often flowed back and forth between topics. Although it was sometimes difficult to keep track of which topics had been covered, it was necessary to maintain the free-flowing conversation desired from the interview approach. The informal nature achieved through this style of interview meant that participants felt more at ease and comfortable discussing sensitive subjects.

It was important to avoid the use of academic language within the interview (Bryman, 2016), as language specific to academia is unlikely to present itself in the daily lives of service users. Therefore, the interview made use of the language used by the participant to ensure they understood what was being asked. For example, terms like 'comorbidity' were excluded

from the interview schedule and the conversation in general. Instead, I explained it in terms of suffering simultaneously from a mental illness and a substance use problem as I felt this was more straight-forward and less jargonistic.

Transcription and Analysis

In line with a naturalistic approach (Armstrong, 2010) and other qualitative research in this field (Bradizza and Stasiewicz, 2003; Harris, Fallot and Berley, 2005), interviews in the current study were audio-recorded (14.6 hours), transcribed verbatim (246 pages), and then thematically analysed to uncover the most salient themes that emerged. Thematic content analysis is a common method of analysis in qualitative research and involves a "constructive, interactive, and interpretive process" to identify commonly mentioned themes that could be categorised into broader categories (Wendt and Gone, 2018: 11). This process involved five main phases:

Stage One: Interviews were transcribed into a Microsoft Word document using the transcription software 'ExpressScribe' to reduce the audio recording to 50% speed. This allowed me to listen carefully to what was being said, familiarise myself with the data, and record any initial impressions. The 'comment' function on Word was used as a 'memoing' technique (Punch, 2014) to record any initial impressions, and any relevant theoretical concepts that related to the data (See: Appendix H).

Stage Two: Once all interviews were transcribed, the analysis process continued during multiple reads and re-reads of transcript data to identify salient and interesting themes that emerged (Flick, 2014; Wednt and Gone, 2018). The themes which emerged were then coded by attaching labels to pieces of the data in each transcript to index it and provide "a basis for storage and retrieval" (Punch, 2014: 173) (See: Appendix H). These themes were refined over the course of continued reading and analysis of the data.

Stage Three: Codes were indexed into a coding frame. This helped organise the codes under broader categories. An example is provided below:

		health experience
Views regarding employment	Problems with employment	Not being ready
		Being scared
		Treatment comes first
	Finding meaningful work	Wounded healer / giving something back
		Enjoyable work / work of personal value
		Dislike of 'means to and end' jobs

The salient themes that emerged through the numerous readings of the transcript data were then given a corresponding colour to help easily identify the data related to each theme.

Stage Four: Each colour-coded section of transcript was then moved into a separate Word document and given a corresponding interview and page number (e.g. 2:34) (Bryman, 2016). The passages of text were categorised in relation to their colour under thematic headings e.g. "facilitators of relapse" (some passages contained a number of themes and were therefore categorised under multiple themes). This breakdown of the transcript data into smaller sections allowed me to easily compare and contrast passages from numerous interviews so that analysis could delve beyond descriptive accounts of the data into broader theoretical concepts (Punch, 2014).

Stage Five: The colour coded document that resulted from this coding process meant that I was able to easily locate transcript data during my write-up and, if necessary, using the corresponding interview and page number attached to each excerpt, return to the transcript to tease out any further data. Responses were then compared and contrasted with the data from the field diary and the existing literature on the subject during the write-up period (Bryman, 2016).

Research Ethics

The qualitative approach requires greater ethical consideration due to my close contact with participants (Renzetti and Lee, 1993). The vulnerability of service users and the sensitivity of the information desired meant that proper ethical consideration was even more significant. Therefore, prior to any field research, this project sought ethical approach from the ethics

committee of Aberystwyth University, which it received. This ensured adherence to all ethical procedures were acknowledged, and implemented.

The aim of the research was discussed openly with clients during participant observation and interviews. Indeed, for the interpretive approach to be successful during this research, the willing consent of all participants was vital. The genuine thoughts and feelings of service users and peer mentors regarding their disorders and the treatment they receive/received for them were only feasible if they were aware of the research and willing to cooperate.

Although it will be discussed in more detail below, it is important to stress at this stage the central importance of anonymity in this research project, and to briefly explain the limitations associated with the level of anonymity required. As discussed at the beginning of this chapter, this research was partially funded by WCADA and as part of the funding obligations, a copy of this thesis was provided to them. As a result, given the small sample size of this project, extra precautions had to be taken to ensure that the anonymity of all participants was maintained. In practice, this meant that I have elected not to include potentially identifying information that is often commonly included in research, such as the specific age or detailed background information of those involved. As this research was based on the establishment and maintenance of trust between myself and the service users engaged with it, and as all participants involved in this research were encouraged to critique any aspect of treatment they saw fit, I felt that extra precautions were necessary to secure the confidentiality of the information provided and the anonymity of those who provided it.

Participant Observation

During participant observation, there were no reservations regarding the nature of the research, as it was important that service users were fully aware of what research they are involved in (Matthews and Ross, 2010). This not only facilitated the establishment of trust between service users, staff and I but meant that service users felt comfortable engaging with me in conversation related to the research topic.

No names or identifying information were included during the write up of my notes to preserve anonymity and protect confidentiality. Instead, pseudonyms or initials were used when necessary. Moreover, all notes were taken on a password protected smartphone and then transferred to a password protected computer.

Interviews

During the interview process, ethical consideration was paramount. Participation in the interview process was voluntary, and prior to the interview beginning, each participant was provided with an informed consent form[30], and participant information sheet[31]. After interviewees signed the consent forms, they had an opportunity to ask any questions about the research. Besides being ethically correct, the openness regarding the nature of the research helped put participants at ease during the interview, which helped facilitate the informal, conversational tone that the interview required. Interviewees were also reminded that they had the right to terminate the interview at any time, and withdraw their information from the study at any point, up until it was anonymised.

As those involved in this study are vulnerable and the topics discussed were of a sensitive nature, there was a risk of interviewees becoming distressed during the interview (Liamputtong, 2007). Recounting what they feel facilitated their substance misuse and induced their mental illness often meant detailing upsetting and sometimes extremely traumatic events in their lives. To address this, at the beginning of each interview, participants were briefed on the research aims and reminded that, given the nature of the research topic, sensitive subjects may emerge. However, they had the right to refuse to answer any question, or avoid any topic that they did not feel comfortable addressing, without explanation. In addition, although only the interviewee and I were present for the interview, all interviews were conducted in the WCADA building and therefore staff were always on hand if necessary. Nevertheless, it was important that I pay close attention to the body language of interviewee, and engage in active, empathetic listening throughout the interview to gage whether a certain topic was causing significant distress. During interviews with a couple of participants whilst

[30] An example of the consent form can be found in Appendix D

[31] An example of the participant information sheet can be found in Appendix B (service user) and Appendix C (staff)

discussing topics that were clearly traumatic, when I saw that service users had become cautious in their responses and risked becoming upset, I reminded them that they did not have to discuss anything that made them feel upset.

Besides being ethically correct, ensuring participants felt comfortable throughout the interview also facilitated communication and the conversational tone sought during the interview (Matthew and Ross, 2010). Besides the informal nature of the interview, the project employed a number of techniques to make sure participants felt comfortable. Firstly, it was important to ensure the interview took place in an environment in which participants were comfortable. As a result, all interviews took place at the familiar setting of the treatment centre in Swansea. Secondly, seating arrangements were important to consider. To avoid the inference of challenging body language, a 'job interview style' seating arrangement whereby the interviewee sits directly across a table from the interviewer was avoided. Instead, I sat at a right angle from the participant, as this allowed both parties to make eye contact and look away comfortably as we spoke (Matthews and Ross, 2010), promoting a friendlier, informal atmosphere. Finally, I also offered a hot drink to all participants during the interview. While this may seem a somewhat trivial step, a hot beverage provides warmth and comfort, and can be raised as a legitimate, acceptable, informal barrier whilst interviewees regain composure and thinking time. This gesture also facilitates the informal nature of the interview, and creates the air of a conversation as opposed to an interview. These techniques were in pursuit of making the experience as unthreatening as possible for participants with the hope of eliciting rich, in-depth data as a result. Biscuits were also provided!

At the end of the interview, each participant was thanked for their participation and debriefed[32]. During debriefing, interviewees were asked if they would like to ask any questions and told that if anything had come up which they felt upset or uncomfortable about, I would liaise with their key worker to ensure the topic was addressed.

The recording of interviews was an invaluable tool in the interpretation and reflection of the data collected post-interview, and provided the freedom to follow the flow of natural

[32] An example of the participant debrief form is provided in Appendix E

conversation without having to pause to take notes (Matthews and Ross, 2010). However, it was important to consider the impact that recording the interview might have on the interviewee. Knowing everything they have said is audibly documented may make interviewees more cautious in what they say, especially given sensitivity of the research topic (Matthews and Ross, 2010). To tackle this, participants were asked if they would be comfortable with the interview being recorded from the outset and were made aware that should they wish to discuss something they did not want audibly recorded, they were free to pause the recording. Furthermore, the purpose for recording, the anonymization process of converting the recording into transcripts, and how the recording would be stored and deleted was also discussed with clients. After the interview had concluded, audio recordings of the interviews were transferred to a password protected computer, and stored using encryption software before leaving WCADA premises. Data will be destroyed once it is no longer necessary for this project.

Confidentiality and anonymity of interviewees were crucial not only to adhere to the correct ethical procedures, but also to give participants the confidence to express themselves freely. During transcription, all data was anonymised and interviewees names were replaced with a number (e.g. Service User 1). During the write-up of my findings, numbers were replaced by pseudonyms. Names of other people which emerged during the interview were also anonymised during the transcript and replaced with contextual information and "name" (e.g. 'ex-partner's name). Additionally, while the current research did indicate the age-range of interview participants, their exact ages were not included. As previously mentioned, I elected not to include the precise ages of interviewees as, given the funding obligations of this project, I was concerned that the small sample size of the study and the detail in which interviewees accounts were described, including this variable may threaten participants anonymity.

Reflections on the Research Process

Building Trustful Relationships

Although qualitative research methodology such as participant observation or in-depth interviewing can be the ideal way to collect data that is sensitive in nature, it also relies heavily

on the establishment of trustful relations between researcher and participants (Renzetti and Lee, 1993; Liamputtong, 2007; Bryman, 2016). As Renzetti and Lee (1993) highlight, researchers interested in disadvantaged populations are often met with scepticism and distrust, fearing only further exploitation. The building of trust is therefore crucial as begrudged participation leads to less in-depth reporting (Renzetti and Lee, 1993). Building rapport is associated with empathy, immersion, participation, honestly and collaboration (Gray, 2014), all of which were pursued in this research as the more comfortable participants felt around me, the more likely I would be given, as Liamputtong (2007: 8) describes as, "backstage access", which helps elicit a richer and more detailed data. As Bowser and Sieber (1993) note, it is better to work with at-risk groups, rather than on them.

As with most qualitative research, especially on vulnerable populations, the current research sought to understand the "meanings, interpretations and subjective experiences" (Liamputtong, 2007: 7) of service users and peer mentors, and this was only attainable through a level of mutual respect and self-disclosure (Denzin, 1989). Participant observation provided an invaluable opportunity to build trusting relationships with service users and staff, whilst simultaneously gathering data on the treatment process (Silverman, 2014). By participating in the daily treatment lives of service users for an extended period of time, I became a usual face to those in treatment and through conversation and daily interaction, I began to bond and establish trust. The DOMINO project especially, was an excellent treatment intervention to build trusting relationships with service users. As the project entailed engaging in activities with service users in a relaxed, therapeutic atmosphere it meant that I was able to interact with service users in an informal manner. This facilitated the building of rapport and meant that I could engage in informal interviewing of research topics during conversations. Also, by participating in the activities myself, I avoided the perception of a passive by-stander, which likely would have alienated me.

Despite the belief that close-proximity with participants can be a negative aspect of qualitative research (Bryman, 2016), the argument can also be made for the opposite. Close-proximity with service users and peer mentors represented an advantage rather than a disadvantage in this research (Armstrong, 2010; Cairns and Nicholls, 2018), as it allowed me to develop positive relationships and gain the trust and respect necessary to discern their

insights and perspectives. Moreover, as I was asking participants of his study to relive potentially harmful moments in their life during this research, I believed they would be more willing to cooperate if I had taken the time to develop a positive, trusting relationship with them; a sentiment upheld by many authors concerned with qualitative research (Denzin, 1989; Renzetti and Lee, 1993; Liamputtong, 2007).

The building of relationships with service users and peer mentors was also aided greatly through WCADA's support as they not only provided a wealth of participants to study, but by accepting both myself and the research project, they immediately facilitated the building of trust between myself and service users (Silverman, 2014).

A Personal Frame of Reference

Mutual disclosure has been highlighted as an important aspect of qualitative data collection (Denzin, 1989). As I discussed previously in this chapter, I have had my own experiences with both anxiety and depression throughout my life. Indeed, it is part of the reason I became interested in researching the topic. As such, I felt it was important to acknowledge my own experiences during discussions with service users, during both participant observation and interviews. I felt this was important for two reasons: (1) to help address the prevailing stigma that surrounds the discussion of mental illness in society; and (2) to help establish a mutual connection that would help develop trusting relationships, a factor important to both data collection and to help put service users at ease when discussing their own experiences. Additionally, qualitative research, especially when concerning vulnerable populations, can often lead to power dynamics (McKay, Ryan and Sumsion, 2003) that are not conducive to the data collection method, particularly in participatory research. Given the pervasive stigma associated with mental illness and drug use, researchers run the risk of being perceived as inhabiting a higher moral ground than those they are researching, despite the inherent inaccuracy of such a perception. This concern is why I found it beneficial during participant observation and interviews to be open to discussing my own experiences of both anxiety and depression when the topic arose. I felt this was important to facilitate the building of trust and to engage in conversations that were based on a level playfield, with mutual trust and respect. I believe the relatability granted through my own experiences with the mental illnesses being discussed, coupled with my willingness and eagerness to participate in

treatment and recovery services helped me develop, as Gray (2014: 444) describes as an 'insider' status. While it was important to ensure, particularly during interviews, that the conversation did not become centred on myself and my experiences, being open and willing to discuss my experience of anxiety, depression and the treatment for these problems, was an important aspect of the data collection process. Having my own experience with anxiety and depression provided me with an acquired understanding of the issues I was asking service users to discuss with me, which meant that I was able to empathise with them from a place of personal experience.

This being said, having my own insight of the disorders involved in this research also presented two key limitations. Firstly, I had to be careful that my analysis was anchored within the scientific literature and not my own personal experience. In practice, this meant double checking whilst conducting my analysis that my interpretations were based in knowledge gleaned from my engagement with the literature and not through my own lived experience. While it was a useful source of insight for me, it was important to remember that I was a researcher and not a participant. Secondly, for someone with anxiety, particularly social anxiety, this type of qualitative data collection (with which I had no previous experience), was far outside of my comfort zone. I found it difficult to approach service users and strike up conversation and felt great anxiety in doing so. However, over the course of the research I become more comfortable and able to manage this and I am very thankful to both the service users and staff who helped a great deal with this, whether they are aware of it or not, through being so friendly and engaging. Not only did I learn a lot about my research topic and the service users I engaged with, I also learnt a great deal about myself and have personally developed as a result of this experience, something which I am eternally grateful for.

Nuanced Understanding

As with much qualitative research, depth over breadth was the salient feature (Silverman, 2014; Bryman, 2016) of this research, as in order for effective programmes to be implemented, the perspectives and experiences of those who are served by the contemporary programmes must be "grasped, interpreted and understood" (Denzin, 1989: 105).

The rigidity of the quantitative approach did not offer the depth or flexibility required to delve into the complex lives of service users or the level of intimacy needed to gather the deeply personal information desired. To get a comprehensive perspective of the world through another's eyes, the qualitative approach was not only preferable, but necessary (Silverman, 2014). For example, while quantitative data has highlighted statistical patters associated with co-occurring disorders (a), such as the high rates of suicide, it does not develop our understanding of the relationship between these two problems or help provide solutions. In contrast, the subjective information derived from interviews and participant observation helped piece together the complex puzzle of factors that operate in the development of co-occurring disorders (c). This depth, built on the detailed and nuanced accounts of service users and coupled with an interpretive analytical approach, has hopefully resulted in a rich discourse in the following chapters that will go some way to improve our understanding of co-occurring disorders (c) and the recovery prospects associated with these disorders. This improved understanding of both the relationship between substance use and mental illness, and the recovery experiences of service users may help develop treatment services and prevent such problems from developing initially.

A Vulnerable Population and Sensitive Research Questions

The population of this study was composed of vulnerable adults and the knowledge desired from the research questions of this project undoubtedly entailed the collection of extremely sensitive and intimate data from the participants of both participant observation and the interviews of the study. A qualitative approach was chosen with the belief that the depth provided through its methodology would do better at providing justice to the traumatic events and experiences often detailed by the services users whilst discussing their lives (Renzetti and Lee, 1993). It was my duty to ensure these accounts were conveyed accurately during the write-up of this thesis with the gravitas they deserved, a task greatly aided through the use of verbatim transcripts.

The qualitative, semi-structured interview style adopted within this research also meant that I was able to gage responses of clients in real-time to acknowledge if an interview

participant was becoming particularly distressed[33], confirming they were okay, reminding them of their right not to discuss a subject or to terminate the interview, and if necessary, moving the conversation onto a different topic. However, contrary to my initial beliefs that the interviews could be distressing for participants, and despite the traumatic nature of many accounts provided to me during this research, all interviewees were happy to provide them in the hope that their candidness would help others in the future. Indeed, a number of participants mentioned to me after the interview had concluded that they were grateful for, and even enjoyed, the opportunity to discuss their life experiences with someone genuinely interested in their story, whose sole purpose was to listen; they valued the chance to "get stuff of their chest". Participants throughout the study (of both interviews and participant observation) noted their appreciation that someone had taken the time to engage with them about their experiences and to learn about the problems affecting them.

Conclusion

In conclusion, this project aimed to examine the recovery experience and treatment process of those with co-occurring disorders (c). Using an interpretive epistemology and a qualitative methodological approach, this research sought to give service users and peer mentors a voice to express their own thoughts and feelings regarding their experience of co-occurring disorders (c) and the treatment process. Participant observation provided first-hand experience of the treatment environment of service users and helped build the trusting relationships necessary for latter interviews.

The research used a mixture of purposive and volunteer sampling to recruit participants for qualitative interviews. Semi-structured interviews provided the opportunity to contextualise the life history of interviewees and draw similarities and compare differences with other service users, as well as with previous research in the field. The inherit flexibility of the approach also allowed for unconsidered avenues to be explored, and gave the interview the air of a friendly conversation on a topic of mutual interest, rather than a

[33] This was achieved through paying close attention to changes in the body language and mannerisms of clients e.g. to note when they attempted to distance themselves from or become visibly upset or uncomfortable around, a certain topic

formalised interview. Interviews were audio-recorded, transcribed verbatim and then thematically analysed to discern the salient themes that emerged from the data.

Ethical considerations were paramount within the current study. The vulnerability of participants and the sensitivity of the research question meant that extra care needed to be taken to ensure the safety of those involved in the study. Therefore, the project obtained ethical approval from Aberystwyth University's ethics committee and took a number of steps to ensure participants felt safe and comfortable during the interview. This included conducting the interview within the familiar environment of the treatment centre, paying close attention to the body language of interviewees, adopting an informal seating arrangement and ensuring that staff were on hand should they be needed.

Treatment for co-occurring disorders (a) will never be a one-size-fits-all model (Hodges *et al*., 2006; Hunt *et al*., 2013; Lai *et al*., 2015) clients are diverse, complex and unique. However, to address the poor treatment outcomes associated with co-occurring disorders (c), we must listen to those experiencing it for themselves as their perceptions and opinions may prove invaluable. The best way to theorise solutions to a problem is to listen to those facing it.

Chapter Three: Facilitators of Drug Use

Factors that service users feel facilitated their drug use are important to consider to help prevent a return to drug use and improve our understanding of the relationship between anxiety, depression and substance misuse. Chapter One highlighted two common pathways through which co-occurring disorders (a) often develop: shared vulnerabilities and the use of substances to cope with dysphoric states associated with a mental disorder. The current chapter also highlighted these two pathways in relation to co-occurring disorders (c) and, as indicated in the literature review, suggests that they are not exclusive. This chapter will explore factors that participants described as facilitating or exacerbating their drug use.

The chapter will begin by examining the role of substance misuse as a method of alleviating symptoms of anxiety and depression, and discuss the plausibility of the self-medication hypothesis. It will then discuss participant's use of drugs to bolster their self-esteem, and then examine the role of drugs in repressing the negative thoughts and feeling associated with past trauma among the women of this study. The subsequent section explores service users' perspective on anti-depressant treatment without adequate mental health support through the NHS, and the exacerbatory effect that being unable to secure psychological therapy has on both their mental illness and their substance use.

The interrelated nature of substance misuse, anxiety and depression detailed in this chapter suggest that treatment would benefit from an integrated approach to substance use and mental health treatment. This is discussed in more depth in the concluding section of this chapter, whilst considering implications for treatment services. However, although I discuss the aforementioned facilitators in depth, there were others that arose during the course of this research with less frequency but are nevertheless still important to reference and consider. These included: homelessness, overly dramatic portrayals of drug use and its effects during school education[34], familial substance use, co-dependant relationships and peer influence (although this is considered in greater depth in the next chapter).

[34] For example, one participant mentioned that after trying heroin once and realising he was not immediately "hooked" (as he had been told would happen in school), he continued to engage with the drug, thinking it was safer than it was

"When you're down, it's a very easy fix": Using Substances to Manage Anxiety and Depression

As highlighted in the literature review of this thesis, anxiety and depression often co-occur with substance use problems (Essau, 2002; Rachman, 2004; Flynn, Brown and Davey, 2016). These disorders often predate any substance use behaviour (Essau, 2002; Khantzian, 2003; O'Neil, Conner and Kendall, 2011, cited in: Sue, Sue, Sue and Sue, 2016), suggesting individuals use drugs in an attempt to cope with, or ameliorate, symptoms of their disorders (Sue *et al*., 2016). This is one of the central tenets of the 'self-medication' hypothesis (Khantzian, 1997; 2003), which posits that individuals are drawn to certain classes of drugs as they find them effective at ameliorating states of distress. However, the author emphasises that substance use is an attempt to reduce "subjective states of distress" associated with the disorder, rather than the disorder itself (p. 235). The current study provides moderate support for the self-medication hypothesis, as many service users described using drugs as an attempt to manage their disorder, but there was little support for the specificity that Khantzian (1997; 2003) claims.

The current study suggests that mental illness and substance use have a synergistic relationship, as one indicative remark from a service user during participant observation highlights: "the more intense my emotion, the more intense my usage". Similarly, during a discussion on the relationship between mental illness and drug use, Edward, who had been a polysubstance user but entered treatment for his problems with alcohol, mentioned that:

> Edward: "Do you know, I, I think I've yet to meet someone with alcohol or drug misuse issues that doesn't have, that hasn't also had, anxiety and depression as well."
>
> Interviewer: "Why do you think that is?"
>
> Edward: "They may be sort of two facets of the same thing. I mean, I'm not saying they don't exist, but I've never met somebody who has said to me 'oh I'm an alcoholic or I'm a drug addict, but I've never had anxiety or depression'. I've never come across anyone who's said that. It seems to be *very, very* [emphasis of participant] interwoven, yeah."

Edward explains that he believes substance use, anxiety and depression are "*very, very* interwoven", and describes them as "two facets of the same thing", indicating the synergy of their relationship. His response highlights how pervasive anxiety and depression is among substance using populations; and while he may simply be referring to universal feelings as opposed to clinical conditions, Edward's coupling of mental illness and substance use implies two important elements. Firstly, that both mental illness and substance use are intrinsically linked with one another, and secondly, that both may be features, or symptoms, of an underlying problem. This suggests that both problems may be a response to external factors, such as life stress. For example, Edward's comment provides a rationale for the strong correlation between mental illness, substance use problems and poverty (Marmot *et al*., 2010). That is, that mental illness and substance use problems are often a response to the distress caused by socio-economic inequality (Hari, 2018). Indeed, previous authors have highlighted the need to consider psychosocial factors such as poverty and its distressing effects within substance use treatment (Drake, Wallach, Alverson and Mueser, 2002; cited in Laudet *et al*., 2004), especially when you consider that the lowest levels of wellbeing are consistently found in the most deprived areas in Wales (Public Health Wales Observatory, 2019). However, this is not to suggest that socioeconomic inequality is the only factor that may influence the development and continuation of mental illness and substance use problems, as various other factors are discussed in this and subsequent chapters.

Morgan, who had entered WCADA for his problems with heroin and had suffered from anxiety and depression since his twenties, highlighted that his drug use was a response to poor mood (Marcel *et al*., 2016):

> "When you're feeling down, it's a very easy fix."

He described becoming more and more reliant on heroin as a way of quelling the anxiety he felt over his future, and the pressure he felt to succeed:

> "I've found a way of escaping from that sort of worry by, you know… doing this, doing heroin; and that's when I started to use it more and more."

However, using heroin to avoid his problem merely exacerbated the distress he was experiencing (Eckleberry, 2004; McCarthy *et al*., 2015), and he began to become increasingly reliant on heroin not only to subdue his anxious thoughts, but also as a method of emotional regulation:

> "...since then [having an existential crisis], I, I was, I was definitely depressed… um, and the… you know, the, the thing that made me feel the best out of all the anti-depressants was opium. You know, were opiate drugs. Um, and it did, you know… they weren't treating it, but there was certainly, you know, there were um… they were alleviating the symptoms you know, temporarily, they were masking the symptoms, yeah."

These excerpts from Morgan's interview contain a number of important elements to discuss. Firstly, he indicates that heroin offered him immediate relief from psychological suffering and that this immediacy trumped the effect of more long-term treatment with anti-depressant medication. This provides strong support for previous research from Harris, Fallot and Berley (2005) who highlighted the same rationale among female trauma survivors with co-occurring disorders (a). This suggests that these results may not be gender specific, and that those with co-occurring disorders (c) are more inclined to seek immediate relief from their distress.

Secondly, while it would appear that Morgan was self-medicating his feelings of depression, as he was seeking "temporary" relief from his symptoms, Morgan does not fit the archetype of the opiate user outlined by Khantzian (2003). A central tenet of the self-medication hypothesis set out by Khantzian (1997; 2003) is that there is a considerable degree of pharmacological specificity involved in drug choice. The author posits that those who are prone to intense, violent and rageful affect are drawn to opiate drugs for their calming properties, whilst those with depressive disorders are drawn to stimulant use as a result of their augmenting effect on vitality (Khantzian, 2003). In contrast, Morgan was using opiates not to subvert wrathful tendencies, but to ameliorate symptoms associated with his anxiety and depression. In fact, he mentioned later in the interview that he disliked stimulants, and felt his personality better suited "downers". As such, this response seems to provide support for the more general explanation of "alleviation of dysphoria", which posits that those who suffer from co-occurring disorders (a) are more prone to dysphoric states and are therefore

more likely to engage with mood-altering substances (Laudet, Magura, Vogel and Knight, 2004: 366).

Thirdly, Morgan's response implies that he was using drugs as a method of avoidance. He describes that heroin was a way of "escaping" his anxious thoughts, and that although opiates "weren't treating it [his depression]", they were "temporarily" "masking the symptoms". This resonates with previous findings from Baker, Piper, McCarthy, Majeskie and Fiore (2004) who have highlighted that escape or avoidance of negative affect are the primary motivation driving problematic substance use. In this sense, drug use offered Morgan "false refuge" (Groves and Farmer, 1994; cited in: Marlatt, 2002: 46) from pain and suffering - despite the immediate relief heroin offered him, avoiding or escaping the problem only served to compound his distress (Marlatt, 2002). Jacobson and colleagues (2001) note that those with depression often engage in avoidant coping behaviours in order to lessen immediate discomfort, but in doing so often exacerbate the problem they are avoiding, and worsen their mental health. Morgan suggests that his drug use was an attempt to lessen his immediate discomfort ("it's an easy fix"), and ultimately exacerbated his worries over his future by developing a substance use problem.

Owen also indicated that his drug use was an avoidance strategy while discussed his rationale for engaging with drugs:

> "I was using mood-altering substances to avoid dealing with anything practically, because I didn't know *how* [emphasis of participant] to deal with highly emotive things. I didn't know how to deal with the practical things like the bills that were building up and all the rest of it. So, when I had a bit of support there, I needed the drugs less and less" … "and it wasn't the case of just using the drugs to deal with the problems, it was using the drugs to help me forget that they were there."

Owen specifically refers to his problematic use of drugs as an avoidance strategy (Baker *et al.*, 2004). He indicates that, in the absence of more positive coping mechanisms, he turned to drugs to "help [him] forget" about his problems, and the negative emotions associated with them. This indicates that the stress associated with not knowing "*how*" to deal with his problems was a primary factor in his substance use (Sinha, 2001; 2008; Davis *et al*. 2018), and that this stress exacerbated his mental illness. Laudet and colleagues (2004) note that stress

and responsibilities may be "particularly challenging" for those with co-occurring disorders (a) as they often lack the necessary skills to cope. Notably, Owen describes that once he had support to help him better respond to adversity, he "needed the drugs less and less". This suggests that for some service users with co-occurring disorders (c), drug use is a coping mechanism (Drake, Wallach and McGovern, 2005) and treatment would benefit from helping clients develop more positive coping strategies.

During a conversation regarding the relationship between mental illness and substance misuse, Christopher seemed to echo the responses of both Morgan and Owen:

> "A lot of people turn to drugs because they're trying to bottle something up, or they can't cope."

Christopher indicates that in the absence of more positive coping mechanisms, drug use is often an attempt at repressing negative emotional states or memories ("to bottle something up"). This seems to support Owen's comment that he was using drugs not to "deal" with his problems, but to help him "forget that they were there". This suggests that for some with co-occurring disorders (c), drug use may be an attempt at avoiding or escaping adversity (internal or external), as they lack the skills necessary to cope with it positively.

Although many participants described their drug use as an attempt at managing their mental illness, many service users acknowledged that substance use also exacerbated their disorder (Eckleberry, 2004; McCarthy *et al*., 2005). Edward, explained that:

> "I won't say I *never* [emphasis of participant] drank because I was feeling anxious, but that wasn't the main reason. Uh, I think that [his drinking problem] was a thing on its own. But it *did* [emphasis of participant] make my anxiety worse. When it got out of hand." … "It's almost like I was drinking to cope with the bad feelings caused by drinking *laughs*."

Contrary to other service users, Edward states that he did not primarily use drugs to relieve the symptoms of his anxiety. However, he did drink more heavily to cope with the anxiety he felt once he began drinking. This suggests that once he began drinking, Edward became

trapped in a self-perpetuating cycle whereby his drinking would exacerbate his anxiety, and he would then drink to manage it, and so forth. As he went on to explain:

> "While I was very drunk, I'd often be *very* [emphasis of participant] emotional. Very upset. Crying. And the next day as well, feeling extremely anxious to the point where I couldn't, most of the time, couldn't resist getting another drink. So, in that sense, it was impacting on my mental health."

Edward states that his drinking was impacting on his mental health, as he "couldn't resist" getting another drink to ameliorate his anxiety the day after. This seems to suggest that Edward's drinking was actually a coping strategy for managing his anxiety, but that his drinking also exacerbated it.

"You're trying to edit yourself really": Using Drugs to Bolster Self-Esteem

Self-esteem is a crucial component of mental health, and is negatively associated with a range of mental illnesses (Silverstone and Salsali, 2003), including anxiety and depression (Birtel, Wood and Kempa, 2017). Those with substance use disorders are often found to have low levels of self-esteem (Khantzian, 1997; Silverstone and Salsali, 2003; Rokach, 2005; Alavi, 2011; Birtel, Wood and Kempa, 2017), as are those who experience anxiety and depression, who are prone to self-deprecating thoughts (APA, 2013). As highlighted by Petersen and McBride (2002), individuals who also experience anxiety and depression are more prone to negative beliefs about themselves and their environment, which often results in the exacerbation of the disorders and a tendency to resort to drug use to manage them (Petersen and McBride, 2002). Therefore, improving levels of self-worth seems an important aspect of treatment for those with co-occurring disorders (c) (Sacks, Ries and Ziedonis, 2005) and facilitators of this will be discussed in Chapter Five (productivity) and Six (peer support and meaningful work).

The current study suggests that those with co-occurring disorders (c) are often attracted to psychoactive substances[35] as a means of ameliorating a feeling of inadequacy.

[35] This term refers to chemical substances that induce temporary alterations in cognition, mood, perception, consciousness and behaviour, and generally refers to all substances encountered within substance use treatment

As one service user remarked to the Personal Development group: "I'm boring without drink". Similarly, during a conversation regarding why he used drugs, Vaughn, who had sought treatment for his alcohol and cocaine use, stated that:

> "I was just, I think yeah, I'm sort of born with it. I'd have to have something. Always have to replace it [cocaine] with something. There's always a way, if I didn't have the pot, I'd go and have a drink. If I can't get pills, I'm gonna have to go and get speed… Needing always something to fix me, because I thought there was something not right."

In his response, Vaughn states that that he "always had to replace it [cocaine] with something", indicating that he never felt comfortable in himself and used drugs in an attempt to "fix" himself. This indicates that Vaughn struggled with poor self-esteem and relied on drugs as a remedy. However, in his response, Vaughn was unable to define what he felt was wrong, stating that there was "something not right". This would seem to provide some support for the argument put forward by Khantzian (2003) that many drug users become dependent as a result of trying to control feelings they do not understand. However, the author believes that drug use is an attempt to exercise control over misunderstood emotional states, rather than relief from them. Whereas Vaughn's response indicates that although he could not deduce what was wrong with him, he was seeking relief from it (i.e. "needing always something to fix me"). Notably, Vaughn also mentioned that he's "sort of born with it" when referring to his problematic use of substances. As he engages with 12-step groups, this may be a reference to the innate character defect which the Alcoholics Anonymous [AA] philosophy describes as the root cause of alcoholism (Kurtz, 1982). However, given Vaughn's acknowledgment that he suffers from feelings of inadequacy, it may suggest that what he was "born with" was poor self-esteem, and he engaged in substance use as an attempt to ameliorate these feelings.

Edward relayed a similar rationale for his drug use:

> "I think some people… do… drink or use drugs problematically to cope with their own emotions. Although I didn't drink on anxiety, I think if I… if I look more deeply into it, I was drinking because there was something about myself that I wasn't satisfied with. That simply just being me, as I am… wasn't enough. So, I tried to tinker with it, or boost it with drink or… or other people. You try to tweak the neurotransmitters, you know.

> Boost it with this chemical, or dampen it down with that chemical. You're not happy with the way you are… so you're trying to, you're trying to amend, you're trying to edit yourself really."

Edward states that he did not drink to self-medicate his symptoms of anxiety, but instead drank because there was "something about [himself]" that he was not happy with, and therefore, he attempted to "edit" himself through his substance use. This indicates that, similarly to Vaughn, Edward was looking for a way to alter his self-perception, and found substance use an effective method for doing this. Although Edward implies that he did not use drugs to manage his emotion, his response suggests that he suffered from negative feelings associated with his own self-image, and drank in response to this fact. Therefore, Edward's response seems to support the self-medication hypothesis (Khantzian, 1997; 2003; Ekleberry, 2004), given that problems with self-esteem are a specific mechanism through which the self-medication theory operates. However, although Khantzian (1997) specifically highlights problems with self-esteem as a mechanism through which the self-medication hypothesis operates, he does not address the role of the thought process in perpetuating self-critical evaluations which may fuel substance use behaviour. As self-esteem is constructed through the beliefs we hold about ourselves, this suggests that the thought process may be an important factor to consider within substance use treatment.

"Just a way to block, or try and block, certain things out": Dealing with Trauma

Self-esteem is also "deeply diminished" in women who have experienced traumatic abuse, and for those also suffer from substance use problems (Harris and Fallot, 2001: 67). A statistic based on US research estimated that "between 55 and 99 percent of women in substance misuse treatment have had traumatic experiences, typically childhood physical or sexual abuse, domestic violence, or rape" (Sacks, Ries and Ziedonis, 2005: 207). As the authors note, this poses a significant problem for substance use treatment, as failing to adequately address the problem can lead to increased substance use, heightened levels of depression, and suicidal impulses.

For many women who suffer traumatic experiences, drug use becomes an effective tool for coping with the negative emotions and thoughts associated with their experience

(Harris and Fallot, 2001; Leeies, Pagura, Sareen and Bolton, 2010). Of the two female participants included in the current study, both had experienced substantial traumatic abuse, and both described how their drug use was an attempt to cope with it. Emily, who had entered treatment for her problems with alcohol, suffered extensive physical and psychological abuse during a co-dependent relationship. When asked when her problems with anxiety and depression began to surface, she remarked:

> "I think it was after… um, the relationship I had with [daughters name]'s father. It sort of started stemming from then like because… it was such a violent relationship and he used to batter me constantly and you know, he'd like, he broke my nose, broke my cheek bones, broke my ribs" … "and after so many years of it then, like it took me down and down so low that I was so depressed and… like… feeling suicidal, wanting to kill myself and everything and… [I] found myself then, when I was going to the shop, I was buying the eight cans but I was also buying a bottle of vodka, keeping it in my bag, and then like because the abuse would be getting worse, I'd like, I'd hide the vodka out the back room and I'd go out there and start drinking, downing it neat like to start, so I'd block him out as well at the same time type of thing. And then if he [went] to hit me then, I wouldn't feel it so much. Like, until the next day obviously when I woke up."

Emily describes how years of abuse had left her feeling depressed and suicidal, and indicates a sequential relationship between her trauma, and anxiety and depression (Hari, 2018). Moreover, she states that her heaviest drinking came about as a direct attempt at coping with the abuse she was experiencing, as she tried to 'block out' the physical pain she was being subjected to. Since this relationship, Emily became increasingly reliant on alcohol to manage the mental illness which resulted from it. She went on to explain that the distress associated with her ex-partner was often a factor in her relapses. Emily described her first detox as "really good", and how she remained abstinent for six months. When asked what happened after those six months, she said:

> "I just… still things were kicking off with [name of abusive ex-partner] and like, things were still happening with him. Like his new girlfriend, she got involved and ended up beating me up for no reason at all" … "and I kept coming out [after detox], relapsing, relapsing… it was just all to do with him and her and just everything really and like my mental health and… awh everything then, and I was… like, [I] tried to kill myself."

Her response indicates that her ex-partner was still a significant source of distress for her, and that her relapses were intimately related to this distress. Emily describes that her relapses were "all to do" with her ex-partner and his new girlfriend, as well as her mental health problems. This indicates the interconnectivity between mental health and mental illness and provides some supporting evidence for the self-medication hypothesis (Khantzian, 1997; 2003), given the interrelated nature of her states of distress and alcohol use. It also indicates that treatment is unlikely to be successful unless significant sources of distress are removed, or alternate methods of coping with the associated stress are implemented. Stress has consistently been highlighted as a risk factor in use of and relapse into, substance misuse (Petersen and McBride, 2002; Andersen and Teicher, 2008; Sinha, 2001; 2008; Brewer, Bowen, Smith, Marlatt and Potenza, 2010; Davis *et al*., 2018). Those with co-occurring mood and anxiety disorders are associated with increased psychological distress, increased risk of responding to adversity with substance use and increased emotional regulation difficulties (Bradizza *et al*., 2018).

Katherine, a polysubstance user who was in treatment for help with her heroin dependency, had also experienced extensive trauma and had suffered from depression since she was a child. From a young age, Katherine was subject to extensive sexual abuse:

> "I was brought up by my Gran. Her ex-husband abused me when I was four… and then I got abused again when I was five, by a gang of older children. Uh, teenagers."

Katherines experience is illustrative of the discourse regarding Adverse Childhood Experiences and their association with substance use and mental illness in adulthood (Ashton *et al*., 2016), as she relates both her mental illness and drug use to her childhood abuse (Hari, 2018) and describes how she used drugs in an attempt to manage the negative feelings associated with the memories of her abuse. This suggests a possible pathway to explain the association between childhood abuse, and co-occurring disorders (c) in adulthood. For example, during a conversation about the history of her depression, the following exchange took place:

> Katherine: "As I said, I suffered with depression… fuck, as far back as I can remember."

Interviewer: “Did that come before the drug use?”

Katherine: “Yeah... and the drug use is just a way to block, or try and block, certain things out, you know… and some drugs just don’t do that in any way, it makes your head think more.”

Interviewer: “So do you um, did you actively make a choice to choose a certain drug for the kind of effects that it had or did you just find that some drugs are better at dealing with it than others?”

Katherine: “At the time it’s whatever drug is in fashion.”

Katherine describes that her problems with depression surfaced prior to her drug use, and that her drug use was an attempt at “blocking certain things out”, suggesting her use was an attempt at thought suppression (Bowen, Witkiewitz, Dillworth and Marlatt, 2007). This resonates with previous qualitative research, which has found that women in substance use treatment with histories of traumatic abuse often suffered from persistent depressive symptoms related to their abuse, and used drugs to suppress unwanted thoughts and emotion (Harris, Fallot and Berley, 2005). Therefore, Katherine’s response seems to both confirm the role self-medication plays in substance use behaviour, and the critique put forward about it. While she implies that her drug use was an attempt to manage her depression, she also states that she did not choose a specific drug for its specific effects (Dixon, 1999; Lembke, 2012; Drake, 2012); stating instead that her drug use followed ambient community patterns (Dixon, 1999).

Dixon (1999) also found that those with schizophrenia avoid drugs that exacerbated their symptoms. Katherine seems to suggest the same thing, as she avoided drugs that made her “head think more”. This point was raised by Khantzian (1997) who stated that “just as a person may discover the appeal and attraction to a particular drug, he or she may also have the opposite reaction – i.e., a marked aversion to a certain class of drugs” (p. 233). Furthermore, Katherine’s use of the word “think” in her response is notable as it suggests a relationship between negatively valenced thoughts and substance use. While this may seem trivial, it indicates a subtle difference, compared to most research, regarding the epidemiology of co-occurring disorders (a), which focuses on negative emotional states (Khantzian, 1997; 2003; Bradizza and Stasiewicz, 2003; Laudet *et* al., 2004; Harris, Fallot and

Berley, 2005). Beck (1979) articulates the sequential but dynamic relationship between negative thoughts and negative emotional states. Following this theory, the high rates of substance use among individuals with anxiety and depression may result from an attempt to manage their increased propensity towards negatively valenced thoughts. This suggests that treatments which directly address a service user's relationship with their thought process, such as mindfulness therapies, may offer an effective treatment for those with co-occurring disorders (c).

"I wanted to get myself sectioned off so I could get the help I needed": Lack of External Mental Health Support

As articulated in the current chapter, anxious and depressive symptoms often facilitate substance misuse. Therefore, addressing these disorders will be important to help service users maintain recovery. However, a number of service users spoke about their frustration at being unable to secure psychological therapy when they first sought help for their mental illness.

Supporting previous research (Rees *et al*., 2015), the current study highlighted that GP's are often the first point of contact for service users seeking help, and therefore GP surgeries present a unique opportunity for signposting service users with co-occurring substance use and mental health disorders to the appropriate services (Welsh Government, 2015). Among individuals in the current study whose first point of contact was their GP, experiences of the interaction varied depending on the level of knowledge the GP had regarding substance use and mental illnesses. However, these interactions were primarily negative, with many highlighting that they would have benefitted from direct referral to substance use or mental health services.

Many service users expressed dismay that the only treatment they were offered for their mental illness was anti-depressants. As a result, some considered drastic measures to try and secure the help they needed:

> "But in this time where I was on a low then, I was seriously thinking about self-harming 'cause I, I wanted to get myself sectioned off so I could get the help I needed. So, I took my uh, my pastor came with me up to the doctors and the GP was like 'There's nothing more I can do for you.'" … "[I was] threatening to self-harm and all that just to get myself sectioned so I could get treatment you know, that's not right is it?"

Keith felt like the anti-depressants were not doing an adequate job of addressing his mental illness, and he became so desperate for more support that he considered self-harming in order to get the psychological treatment he needed. He has now been on a waiting list for "eight or nine months". Keith's story paints a typical picture of the mental health services in the UK which, like substance use services, are chronically under-funded for the workload they are presented with (UNISON, 2019).

Keith, like a number of other service users in this study, described visiting his GP for help with his anxiety and depression, and medication being the only avenue available. Indeed, many service users described being referred to a psychiatrist just so that they could be prescribed alternative anti-depressants. Katherine explained that she was taking "all the anti-depressants in the fucking world", but never getting the "proper help" she wanted from her GP:

> Katherine: "I was taking all the anti-depressants in the fucking world, topped with my painkillers, for my legs and my back. My doctor, I think I got to the stage where I was just nagging. It seemed like I was going there, and I was trying to explain what was wrong and the help I needed... but never getting the proper help. It was like, these tablets that he put me on, first of all, it was 'just take two a day, one in the morning, one in the night'. Then it was 'take four a day'. Higher[ing] the dose, just to keep me away basically. It was like 'We've given you everything'."
>
> Interviewer: "What kind of help did you want, if he could have offered it?"
>
> Katherine: "To go and see a counsellor, to go and see someone, to actually talk to somebody. To be *able* [emphasis of participant] to talk to somebody. You know it was, 'You need to stop using your drugs' and it was like 'I know I need to stop using them, I want to stop using them, but at the same time I can't just…'."

Despite the drive to increase access to psychological therapy in Wales (Welsh Government, 2016), Katherine also describes desperately trying and failing to get psychological therapy for her mental illness from her GP. She explains that instead of anti-depressants, she wanted to

see a counsellor so that she could talk about her mental illness and the problems associated with it. This indicates the value service users place on psychological therapy for their mental illness. Katherine emphasised that what she really wanted was the opportunity to be able to talk about her mental illness with somebody, something that she expressed later in the interview when she spoke about her gratitude for peer-led group treatments[36]. The final sentence of Katherine's response is notable. She describes being told by her GP that she needed to stop using drugs, and that, although she wanted to, she did not feel she could. Given that this remark was made during a conversation about mental illness, this indicates that Katherine perceives the two to be interrelated, supporting the argument made in the present and following chapters of this thesis. Given the interrelated nature of mental illness and substance use problems, being unable to gain adequate support through the mental health services when needed may facilitate substance use by exacerbating the mental illness that service users are attempting to manage with drugs.

Although many service users, including Katherine, receive counselling for their mental illness through WCADA and place significant value on it, having to assume the responsibility of care for mental illnesses without an increase in funding to support it may place an undue strain on substance use treatment centres. The good practice guidelines for treatment of those with co-occurring disorders (a) emphasise joint responsibility between the mental health and substance use sectors (NICE, 2016; Christie, 2017). However, this study suggests that, contrary to these guidelines, the substance use sector is assuming the sole responsibility of the treatment that those with co-occurring disorders (c) desire (psychological therapy). The responses from Katherine and Keith indicate that this is the result of inadequate signposting from GPs toward psychological treatment and chronic underfunding of mental health services in the UK, which results in a lack of access to appropriate psychological support or extensive waiting lists for therapy.

A number of staff during the study discussed that there are often disputes between substance use and mental health services regarding which service should take responsibility

[36] The role of group treatment in the recovery process of service users, as well as peer-support more generally, is discussed in more depth in Chapter Six

for clients with co-occurring disorders (a). As Owen, a peer mentor working with WCADA, noted:

> "It's like two divorcing parents arguing over a kid who's just standing there watching them both" ... "it's like a weird pinball machine that the client is just bounced around sometimes."

Owen's "divorcing parents" analogy is notable as it implies a strained relationship between the two services, and suggests that service users may suffer as a result. This supports American research which highlighted that service users with co-occurring disorders (a) are at risk of "fall[ing] through the cracks" and not receiving adequate treatment (Sacks, Ries and Ziedonis, 2005: 4); making Owen's "pinball machine" analogy rather apt. Moreover, this lends support to a recent EU report which stated that the separation of substance use and mental health services represents a barrier to effective treatment for those with co-occurring disorders (a) (Torrens *et al*., 2015). A separation that is emphasised and accentuated partly through alternate funding streams (NICE, 2016).

Implications for Treatment

As exemplified above, it would seem that anxiety, depression and substance use are deeply intertwined in a synergistic relationship. Service users sought relief from the dysphoria they experienced, which was both a cause and consequence of their co-occurring disorder (c). However, they often exacerbated their conditions in doing so (Eckleberry, 2004). This lends support to the importance previous research has placed on cultivating human capital in recovery, through developing positive coping mechanisms to better manage adverse experiences. The current research suggests that human capital is an especially important aspect of recovery for those with co-occurring disorders (c), given their tendency to resort to substance use to manage the poor moods associated with their disorders.

It would follow that, given the interwoven nature of mental illness and substance use, treatment for those with co-occurring disorders (c) should address both conditions concurrently (Petersen and McBride, 2002; Daley and Moss, 2002; Sacks, Ries and Ziedonis, 2005; Flynn and Brown, 2008; Welsh Government, 2015; Torrens *et al*., 2015; Murthy *et al*.,

2016; NICE, 2016; Priester *et al*., 2016; Christie, 2017). Indeed, the importance of this was articulated by Katherine when asked if she believed her mental health or drug use should be tackled first:

> Katherine: "For me it was... a bit of both, you know. Like I was, I started to get a handle on coming here, you know, getting help for my drug use, and at the same time then I got the help… for my mental health."
>
> Interviewer: "Is it important to happen at the same time?"
>
> Katherine: "Yeah, and that was the nice thing; it kind of came at the right times for me. You know, I was getting a handle on my drug use and I could sort out the problems in my head, cause if they don't get sorted, my drug abuse would've gone back, I know it would of, because… as I said it's, for me, it's kind of like a battle between the two of them, you know?"

Along with further supporting the intrinsic connection substance use problems can have with anxiety and depressive disorders, Katherine's response highlights the importance of treating both her substance use and mental health problems simultaneously. She states that if her mental health problems had not been addressed, her drug use would have returned, as the two of them have a synergistic relationship ("it's kind of like a battle between the two of them"). Katherine's response also highlights that stabilisation is an important aspect of treatment. Treatment provided Katherine the space to take a step back and address the issues that were facilitating her drug use and created a sober window that encouraged recovery. However, it suggests that while treatment is able to help stabilise service users, long-term recovery is conducive on a variety of other factors, some of which are discussed in Chapters Five and Six. This emphasises the connected but distinct realms of treatment and recovery discussed at the beginning of this thesis.

This chapter has also suggested that service users place more value on psychological rather than medicinal therapy for their anxiety and depression. Therefore, although a number of service users received support from WCADA for their mental illness, the lack of mental health support available through the NHS may act as a barrier to successful recovery.

Of note however, was the value that Katherine, and other service users, placed on having mental health treatment integrated within their substance use treatment. This is likely

a result of the positive relationship service users had already built with their WCADA counsellor. As Katherine explained when discussing the possibility of external therapy:

> "I'd prefer to stay here, where I feel comfortable, and not start somewhere new…"

Katherine was reluctant to seek external therapy to address her mental health problems, as she felt "comfortable" at WCADA. This is supportive of previous research on women trauma survivors who articulated their preference for integrated treatment in one location (Harris and Fallot, 2001). It may also convey the broader point that although service users may seek psychological support through their GP, they are content with (and may even prefer) integrated psychological treatment once they engage with substance use treatment services. As the focus of the current policy in Wales is on collaborative treatment approaches between mental health and substance use services (Welsh Government, 2015), more research is required to address whether collaborative or integrated treatment would best serve this client group.

Conclusion

In summary, this chapter has highlighted an intrinsic relationship between mental illness and substance use. In support of the guidelines for treating those with co-occurring disorders (a) set out by Public Health England (Christie, 2017), this research suggests that treatment should recognise the synergistic relationship between the two disorders, rather than seeing both conditions as separate entities. As articulated by the service users, substance use is often a method of coping with a mental illness that has preceded it. For some service users, substance use served as an avoidance strategy to distance themselves from the distress they were experiencing, both as a result of external and internal factors. For others, it was a direct attempt to compensate for their lack of self-worth and they engaged in substance use in an attempt to "edit" themselves into a more desirable version. For the women in this study, substance use served as a mechanism through which they managed the negative feelings associated with traumatic experiences. Given the commonalities surrounding the motivation for engaging with sustained drug use (i.e. as a coping mechanism) among participants with co-occurring disorders (c) in this study, this chapter lends support to previous research that

has highlighted the importance of cultivating human capital in the form of more positive coping mechanisms (Cloud and Granfield, 2009) and suggests this may be especially important for those prone to poor mood.

The common connection between participants was that their substance use directly related to alleviating states of distress and dysphoria, which suggests that their anxiety and depression were the driving forces behind their drug use. While this research does not provide adequate support for the self-medication model, given its emphasis on specificity, it does support the more general 'alleviation of dysphoria' theory (Laudet *et al*., 2004). Given the apparent entwined and synergistic relationship between anxiety, depression and substance use, treatment will likely benefit from addressing these conditions simultaneously. However, more research is required to assess whether integrated or collaborative treatment would be best suited for those with co-occurring disorders (c). Nevertheless, it seems that improving the self-worth and mental wellbeing of service users will be an important facilitator in treatment success. Chapters Five and Six will discuss treatment interventions that were highlighted by service users as being important in addressing these factors.

While much research has focused on the association between substance use and emotional regulation, this study suggests that suppression of anxious and depressive thoughts is a primary rationale behind continued substance use. This suggests that interventions that directly target the thought processes, such as CBT or mindfulness-based interventions, may present an effective treatment modality for those with co-occurring disorders (c).

A number of service users also spoke about their dissatisfaction with a purely medicinal approach to their anxiety and depression through anti-depressant treatments, and their preference for psychological therapy. Although service users placed great value on the counselling they received through WCADA, many expressed frustration at being unable to secure psychological therapy through the NHS prior to receiving this, and suggested that this had had an exacerbatory effect on both their mental illness and substance use. The somewhat turbulent relationship between the mental health and substance use services was also highlighted, which may be problematic for those with co-occurring disorders (c).

Chapter Four: Barriers to Recovery

The previous chapter discussed factors that may facilitate the initiation of substance use. This chapter will explore factors highlighted by service users as representing risks of relapse[37], as these are important to understand in order to improve treatment efficacy and prevent future relapse. By examining these barriers in the rich detail afforded by a qualitative methodology, these factors may be better grasped and understood.

To begin, the chapter will examine drug-oriented friend groups and the risk they continue to pose to successful treatment and recovery. Next, the role of feeling lonely and bored are explored in relation to their exacerbatory effect on mental illness through heightening negative thought processes. Following this, stigma is discussed with reference to both negative and positive aspects of it. Finally, the chapter discusses the Department of Work and Pensions (DWP) and the negative impact that this organisation can have on the recovery of service users with co-occurring disorders (c), particularly in regards to the financial insecurity associated with relying on this service for support and the stress associated with having one's benefit revoked. Additionally, this section covers the conflicting views of the Job Centre and the substance use treatment services on employment and their difficulty in navigating these opposing opinions. For example, service users described feeling dismayed at being advised by treatment services to avoid returning to work before they are ready, but being pushed toward finding a job by the Job Centre.

Generally, these factors revolve around their exacerbatory effect on the mental illnesses of service users, suggesting that as well as being linked with the initiation of use, anxiety and depression are also deeply entwined with relapse into substance use problems. However, it is important to note that while these factors are discussed in more depth, there were others highlighted throughout this research that may warrant greater investigation in

[37] It should be clarified that while all risks associated with relapse are barriers to recovery, not all barriers to recovery are risks of relapse. However, this chapter discusses factors associated with relapse under the chapter title of Barriers to Recovery anything that increases the risk of relapse should be considered a barrier to recovery.

future research. These included a lack of transport to and from services[38], sudden bursts of money (particularly attributed to changes in Universal Credit provision) and the limitations of day time only service provision for those who manage to secure employment.

"It wouldn't be in my best interest to mix with them at the moment": Peer-Group Use

Substance use often occurs in adolescence (Petersen and McBride, 2002; Davey, 2016; Sue *et al*., 2016), and although for the majority this is only experimental and does not translate into problematic use in adulthood (Aldridge, Measham and Williams, 2011), for those who do develop substance use problems in later life, they have often accumulated an extensive social network of drug-using peers by the time they seek treatment for their problem. These drug-oriented social networks are problematic for recovery, as they present a strong pull to return to substance use behaviour, and interaction with such groups often precipitates relapse (Bradizza and Stasiewicz, 2003; Laudet *et al*., 2004; Harris, Fallot and Berley, 2005; Laudet, Morgen and White, 2006; Marcel *et al.*, 2016).

Christopher described getting himself sober after moving away for a job, but how he then ended up relapsing once he returned home and re-engaged with his old social network:

> "When I came back, I had a lot of money… I ended up after about six months, hanging back around with the same people who I used to use with years ago, and then I ended up using again."

Christopher states that even after "years" of not using, once he returned to socialising within his drug-oriented social network, he relapsed within a relatively short period of time. This suggests that re-engagement with drug-oriented social groups remains a risk factor for relapse even after long periods of abstinence. Therefore, treatment may benefit from facilitating the development of new, recovery-oriented social circles, something which is examined in more depth in Chapters Five and Six.

[38] Lack of transport to and from services may be seen as one example of a barrier to recovery that does not necessarily constitute a risk of relapse

A similar sentiment was articulated by Nathan, who described how his old friend group taunted him when he saw them out in town, once he had distanced himself from them:

> "[they were like] 'Oh, you're too good for us now?' When I seen them out and all that."

He went on to explain that this peer-pressure from his old friend group caused him to relapse once he re-engaged with them:

> "So then I went into doing loads of pills again and, 'cause I stopped doing pills for a few years 'cause my head went a little bit, and then I started doing them again and one of the boys just turned around and was like 'Fucking hell [Nathan], you need to do pills again like. You made us laugh like fuck tonight, more than you normally do'. You know, and then I got into doing them again for… I was selling them, I was doing, probably, about thirty or forty a week."

Similar to Christopher, Nathan states that re-engaging with his drug-oriented friend group caused him to relapse. Notable though, is his description of a conversation in which he was told he was more entertaining to be around when he was high, as he implies this was the reason he started using heavily again. This suggests that Nathan suffered from poor self-esteem and internalised this comment as proof of his inadequacy whilst he was sober. Supporting evidence from the previous chapter, this indicates that problems with self-worth may be a risk factor for relapse, as well as a facilitator of use.

Morgan also emphasised that his old friends continued to pressure him to re-engage with them for a substantial amount of time:

> "For a *long* [emphasis of participant] time though people sort of… they're not wishing that you'd relapse in a way, although they do miss you in a way, from the social circle" … "there are a few people I, I *do* [emphasis of participant] miss, and that, you know, I know are very good people underneath, it's just that, I know that it wouldn't be in my best interest to mix with them at the moment, you know."

Morgan states that his friends pressured him to return to the group as they missed having him around (Davis and O'Neil, 2005) and that although he did not want to re-engage with them, he did miss some people from the group. Given that many of these friendships have

developed over decades, it is perhaps understandable that service users feel a strong pull to return to previous friend groups. As a result, many service users may need to develop new social networks to replace old, drug-oriented ones. As Strang and colleagues (2017) note, the risk of relapse rises with the number of drug-oriented friends in a service user's social network, and declines in relation to the number of recovery-oriented friends. As will be discussed in Chapters Five and Six, socialisation within treatment may play an important role in addressing this.

The responses of Christopher, Nathan and Morgan suggest that maintaining contact with actively-using social networks may constitute what Cloud and Granfield (2009) describe as 'negative recovery capital' and therefore present as a barrier to the cultivation of recovery capital and recovery itself. This is supportive of research from Rosenquist, Murabito, Fowler and Chirstakis (2010) who found that for each additional member of a participant's social network who drank heavily, the likelihood that they would also begin drinking heavily increased by 18%, whereas, contrastingly, for each additional abstaining member of a participant's social network, the chances of the participant themselves abstaining from alcohol increased by 22% (cited in: Best, McKitterick, Beswick and Savic, 2015).

The negative consequences associated with maintaining contact with substance-using social networks also lends support to the notion of social recovery capital[39] (Cloud and Granfield, 2009; Best and Laudet, 2010; Hennessy, 2017) given the risk of relapse associated with maintaining contact with actively-using social networks. As Collinson and Best (2019: 2) state: "To sustain recovery, the individual must move away from groups whose norms are centred on substance use and move towards groups whose norms do not support heavy substance use, with resulting implications for their self-identity". The role of developing and maintaining supportive relationships with recovery-oriented peers is discussed in more depth in Chapters Five and Six.

[39] Social Recovery capital refers to the sum of resources an individual may draw upon from their relationships and social networks to support their recovery journey, and also their commitments and obligations to these relationships and groups (Best and Laudet, 2010)

"I was feeling bored. So, I thought 'Sod it, I'm going to have a few drinks and see how it goes": Loneliness and Boredom

Disengagement from substance-associated social circles often leaves many of those entering treatment and embarking upon the recovery journey feeling isolated (Hawkins and Abrams, 2007). This is problematic for recovery prospects as loneliness is associated with increased levels of anxiety and depression[40] (Rokach, 2005; Hari, 2018; Welsh Government, 2016; Cacioppio *et al*. 2002; Stroebe and Stroebe 1996; Uchino 2004, cited in: Birtel, Wood and Kempa, 2017), increased drug use (Witkiewitz *et al*., 2014; Christie, 2017), and the likelihood of being negatively affected by stress (Gilson, Freeman, Yates and Freeman, 2009). Public Health England guidelines for the treatment of those with co-occurring disorders (a) state that it is "vital" for treatment services to recognise and address social isolation given its association with relapse, worsened mental health and the exacerbation of mental illnesses (Christie, 2017: 34).

The current research also highlights the link between social isolation and worsened mental health. For example, during an informal interview during a structured walk with the DOMINO Project, one participant remarked that: "When I'm isolating my mental health suffers. That's when I get the urge to use".

Emily also explained that being alone in her house led to spiralling negative thoughts, which resulted in relapse:

> "That's when it [her drinking] got worse when I was still in the house and I was on my own, because I didn't have no friends; didn't see my children anymore; and I thought 'What's the fucking point in going on anymore?' Do you know what I mean? In the end, I just thought I'd drink myself into oblivion and more and more and more."

Emily's response indicates that isolation may exacerbate depressive thoughts, promote suicidal ideation and facilitate relapse among those with co-occurring disorders (c). She suggests that she had no friends, or interaction with her children and that this led to her

[40] Both of which, as is discussed throughout this thesis, are associated with an increased propensity toward substance use

contemplating suicide and eventually relapsing in an attempt to escape these thoughts. This suggests that the high rates of suicide associated with co-occurring disorders (c) (Torrens *et al*., 2015; Christie, 2017; Strang *et al*., 2017) may be the result of social isolation and its exacerbatory effect on service users' mental illness. Furthermore, Emily's emphasis on the role her thought process played in her relapse provides evidence for the role rumination plays in substance use problems (Nolen-Hoeksema and Harrell, 2002; Nolen-Hoeksema, Stice, Wade, Bohon, 2007, as cited in: Brewer, Bowen, Smith, Marlatt and Potenza, 2010) and supports evidence from the previous chapter. Rumination describes a behaviour characterised by excessive dwelling on one's negative thoughts and emotions with no engagement with active problem solving (Brewer, Bowen, Smith, Marlatt and Potenza, 2010). Heightened levels of rumination have been associated with increased risk of relapse in depression (Whitfield and Davidson, 2008) and an increased inclination to use alcohol (Brewer, Bowen, Smith, Marlatt and Potenza, 2010). This gives some support to the idea that drug use is often a method to manage or suppress unwanted thoughts and the negative feelings that follow; suggesting a sequential link between depressive states and substance use (Khantzian, 1997; 2003).

Isolation has also been coupled with boredom by previous authors investigating service users with co-occurring disorders (a) (Laudet *et al*., 2004; Harris, Fallot and Berley, 2005). The current study also suggests they may be homogeneous and that both are associated with risk of relapse. When asked what was happening around the time he last relapsed, Edward responded:

> "Um, that's a strange one that is because people are, people have said that they… a couple of people close to me had said that they could see that I was going downhill mentally. But um, I wasn't um… I didn't… in my mind on the day I drank, I didn't drink because of that." … "I didn't think 'Oh, I'm feeling down, so I'm going to drink.' I just felt bored, I was feeling bored. So, I thought 'Sod it, I'm going to have a few drinks and see how it goes.' But unfortunately, it was a two day; luckily, it was only two days, but it was a bender."

Edward described that although those around him had commented that his mental health appeared to be "going downhill", he did not drink in response to "feeling down" but that he "just felt bored". While this would seem to provide evidence in contrast to that which

describes drug use as a coping strategy to deal with negative emotion (Khantzian, 1997; 2003; Ekleberry, 2004; Drake, Wallach and McGovern, 2005; Harris, Fallot and Berley, 2005), it is likely that Edward's feelings of boredom were elicited in response to him being alone in his flat. Therefore, in Edward's case, one may describe boredom as a negative emotional state given its association with isolation. Additionally, it is important to note the final sentence in Edwards response, as his replacement of his earlier word "unfortunately" with the contrasting word "luckily" when discussing a relapse implies that his recovery has involved a change in his thought process away from a negative mindset and toward a positive one. This is important to highlight given the benefits associated with a strengths-based system within treatment and recovery (Best, Edwards, Mama-Rudd, Cano and Lehman, 2016; Best, 2017).

Merriam-Webster (2019) defines boredom using two negative adjectives, as: "the state of being weary and restless through lack of interest". Given the link between boredom and drug use, this indicates that treatment should address feelings of boredom by stimulating the interests of service users. Edward went on to discuss this, and articulated that the more time he spent in positively reinforcing activities, the less he needed drugs:

> "I think the more active you are, and the more involved in other things you are, the less likely you are… to uh, I mean it's not black and white, but I mean, overall you're less likely to… the less time you have to just dwell, to just *think* [emphasis of participant], the less likely you are to do things like drink or using drugs."

Edward's response suggests that treatment would benefit from providing positively reinforcing activities for service users to engage with to ameliorate feelings of boredom and isolation; something that is discussed in more depth in Chapter Five and which also fits with the work of David Best and others who have highlighted the importance of meaningful activities within recovery (Best, Savic, Beckwith, Honor, Karpusheff and Lubman, 2013; Best, McKitterick, Beswick, Savic, 2015; Best, Beckwith, Haslam, Haslam, Jetten, Mawson and Lubman, 2016). Furthermore, Edward stated that the less time one spends dwelling on their thoughts, the less likely they are to use drugs. This suggests that feelings of boredom may be associated with an increase in negative thoughts and feelings, evoked through being uncomfortable in one's own company. His emphasis on the word "*think*" in this sentence is also notable, as he implies that drug use is a response to negatively valenced thoughts, which

provides further support to evidence the role rumination plays in exacerbating substance use. Moreover, Edward's response indicates that drug use may be a method of thought suppression (Bowen, Witkiewitz, Dillworth and Marlatt, 2007), providing support for the human capital aspect of recovery capital, which relates to the importance of developing positive coping skills in sustaining recovery (Cloud and Granfield, 2009).

Harris and colleagues (2005: 1296) state that treatment should "attend closely to negative emotions such as boredom and loneliness", as these were highlighted as frequent predictors of relapse. The evidence provided by the current study seems to support this view. This suggests that treatment may benefit from promoting opportunities for socialisation, as this would reduce isolation and boredom, both of which seem to be associated with relapse, and improve the mental health and recovery prospects of clients. This supports the treatment guidelines set out by Public Health England, which state that groups and opportunities which help reduce social isolation play a "crucial role in enabling and sustaining recovery" of service users with co-occurring disorders (a) (Christie, 2017: 34). Indeed, WCADA has recognised this, and developed DOMINO, a therapeutic program of diversionary activities wherein service users can informally socialise with one another. This is discussed in more depth in Chapter Five.

"It does get to me sometimes, being judged outside": Stigma

Substance use is associated with a far higher levels of stigmatisation than other health conditions (Corrigan, Lurie, Goldman, Slopen, Medasani and Phelan, 2005; Room, 2005; Rao, Mahadevappa, Pillay, Sessay, Abraham and Luty, 2009; Ronzani, Higgins-Biddle and Furtado, 2009; Schomerus, Lucht, Holzinger, Matschinger, Carta and Angermeyer, 2011; cited in: Livingston, Milne, Fang and Amari, 2011), and has substantial implications for those who experience it. It is associated with poor levels of self-esteem (Sue *et al*., 2016), heightened levels of anxiety and depression and increased social ostracism, which also exacerbates anxiety and depression (Birtel, Wood and Kempa, 2017). Both substance use and mental illness carry their own stigma and as such, the stigma associated with each is compounded for those who experience both concurrently and creates a significant barrier to successful

treatment for those with co-occurring disorders (a) (Mojtabai, Chen, Kaufmann and Crum, 2014; Motta-Ochoa *et al*., 2017). Indeed, previous research has indicated that drug users, especially women (Copeland, 1997; Wechsberg, Luseno and Ellerson, 2009; Stengel, 2014) and the homeless (Copeland, 1997; Reid and Klee, 1999; cited in: Neale, 2001), may be reluctant to access specialist services in fear of being labelled or stigmatised (Semple, Grant and Patterson, 2005; Digiusto, Treloar, 2007; Keyes *et al*., 2010; cited in: Milne, Fang and Amari, 2011).

Christopher explained that he often felt looked down upon as a result of his substance use problem, and he felt like the 'addict' stigma was associated with a certain stereotype (Sue *et al*., 2016):

> "People look down upon it [substance use] and put you socially… you either come from a poor background or you've been in a lot of trouble with the police or… it's all of that sort of stigma to it."

Christopher indicates that it is not just the 'addict' stigma that service users must contend with, but also the associated stigmas related to assumptions about poverty and crime. This suggests that those with co-occurring disorders (c) experience a variety of related stigmas associated with a perceived-lifestyle. In this sense, their experience relates to the discourse of authors who espouse the ideas of multiple jeopardy in terms of stigma. For example, (Rosenfield, 2012) argues that the negative effects of stigma are compounded for those who hold a variety of stigmatised attributes (e.g. female gender, poverty stricken/low social class, ethnic minority). Granfield and Cloud (2008) even went so far as to classify mental illness and the female gender as elements constituting 'negative recovery capital' as they act as a barrier to recovery (cited in: Best *et al*., 2016*b*).

The current study also highlighted that stigma associated with drug addiction can have serious implications for the mental health of service users and can exacerbate their mental illness, as Emily notes:

> "It does get to me sometimes, being judged outside [of WCADA]. Like when people are like 'Oh look at her'. Then you get the odd remark or comment and you think '*sighs*'

> you know 'Just fuck off because I can't even be bothered to even explain myself.' And I think, 'Why should I have to explain myself to anybody else? It's my life'."

The sigh Emily emitted during her response would seem to infer her exhaustion she felt toward dealing with the stigmatised opinions of her, suggesting how often she encounters such opinions. She went on to describe how she felt after being told she looked like an "alchy [alcoholic]" by a stranger:

> "I was thinking, 'Oh God. My life is so shit. I may as well go and *kill myself* [emphasis of participant] anyway."

As Emily describes, stigmatisation had a negative effect on her self-worth, which is problematic for recovery given that it has a negative impact on service users' mental illness and its association with increased substance use as a result, as highlighted in the previous chapter. Furthermore, the experience elicited suicidal ideation in Emily. Given the high suicide rates associated with those suffering from co-occurring substance use and mental disorders, stigma represents a clear danger for those with co-occurring disorders (c) in recovery. Emily's response suggests that the high rates of suicide found among those with co-occurring disorders (c) may be, in part, the result of stigma and the exacerbation of depressive thoughts associated with it. Moreover, Emily's use of the verb "thinking" instead of "feeling" to describe how she reacted to being stigmatised is notable as it lends support to the notion that thoughts are the primary driver of mental illness (Beck, 1976). This resembles evidence provided in the previous chapter regarding the sequential relationship between negatively valenced thoughts and substance use.

Experiences with stigma are perhaps a significant factor behind why service users appreciate peer-led support in substance use treatment and recovery. As will be discussed in Chapter Six, service users described the value they saw in being able to talk about subjects which would otherwise provoke a judgemental response, and how they felt safe in discussing stigmatised topics without fearing that they would be judged.

However, there was some evidence that stigma from familial relationships may facilitate treatment initiation. As Morgan stated:

> "Some of my aunties and uncles sort of avoided me almost and you know, I suddenly felt a little bit of a sort of 'Oh wow, if I don't sort myself out, they're going to, uh, at some point they're going to have had enough and they're going to actually think, you know… we can't keep sort of, you know, condoning what you're doing by not saying anything'. So that was a bit of a wake-up call as well I suppose."

Morgan highlights that stigma or the perceived exhaustion of his family regarding his behaviour may also act as a motivator to seek treatment. He describes that realising some of his extended family had begun to avoid him, acted as a "wake-up call" that led him to re-evaluate his position and decide to "sort [himself] out". His response resonated with an interaction I had with a peer mentor during participant observation who described feeling embarrassed that she was the only unemployed member of her family and that this drove her toward seeking help for her problems with alcohol. Both the interaction I had with the aforementioned peer mentor and Morgan's response, suggests that stigma, when it is from the right people, may not represent as a barrier to recovery, but may be a motivator prompting individuals to engage with treatment. However, he went on to state that once he entered treatment, the support of his family played a "huge" role in his recovery journey:

> "The family support is a, is a *huge* [emphasis of participant] one to be honest, and you know, not being judged by my family as well. You know, my parents for example are genuinely proud of me for… I don't like to use the word beating it, but um, you know, for getting to where I am now and eventually holding my hands up."

This suggests that although mild stigma may push service users to seek treatment, once they have sought it and are engaging with it, familial support is a vital element in the recovery process.

"It's not a caring system really, is it?": Conflict with the Department of Work and Pensions

Many service users within treatment will not be in employment (Maguire, Holloway and Bennet, 2014) and as a result, the majority of service users will be in receipt of benefits from the DWP to survive. However, the current study suggests that service users' relationship with the DWP may be a barrier to recovery for three main reasons: (1) the threat of sanctions or

removal of benefit; (2) the negative impact that having to survive on benefits has on mental health and its potential to exacerbate mental illness; (3) the conflicting attitudes of the DWP and substance use services with regard to employment. Each of these is discussed in greater depth below.

The Threat of Sanctions or Removal of Benefit

The majority of service users in the current study suggested that their interaction with the DWP was problematic for their recovery, owing to its negative impact on their mental health and exacerbatory effect on their anxiety and depression. As highlighted in the current and previous chapter, drug use and mental illness seem to have a synergistic relationship, and each often exacerbates the other (Eckleberry, 2004; McCarthy *et al*., 2005). As such, situations which negatively impact upon a service users' mental illness may be seen as a barrier to recovery. Service users in the current study who received Universal Credit highlighted that the threat of sanction was a significant source of stress and anxiety. For example, Keith noted:

> "I know you've got more stress being under Universal Credit because you're worrying about sanctions… 'Have you done enough this week? Have you done enough that week?' you know? I'm trying to save money where I can, as I said, I cancelled my Sky subscription. Next thing I know, I could end up getting sanctioned and I've got all this worry on my head then. You know, 'How am I going to do this?' 'How am I going to pay this bill?' You know what I mean? 'How am I going to pay that bill?'" … "It's not a caring system really, is it?"

Keith describes that the threat of sanctions from the DWP and the worry regarding the financial hardship that would result from being sanctioned causes him a great amount of stress and anxiety, and he describes the welfare system as "not a caring" one, indicating that he feels the support he receives is not compassionate. Stress plays a significant role in the initiation, perpetuation and relapse of mental illness and substance use problems (Sinha, 2008; Davis *et al.*, 2018) and induces similar changes in the brain to those associated with addiction (Polter and Kauer, 2014), such as increased impulsivity (Esch, 2014, cited in: Davis, *et al*., 2018). Indeed, it has been suggested as an underlying vulnerability affecting both addictive and affective disorders (Sinha, 2008; Garland *et al*., 2016). As those who suffer from co-occurring disorders (c) are associated with an increased risk of experiencing distress, and an increased risk of responding to adversity with substance use (Bradizza *et al*., 2018), the

stress associated with the threat of sanction may be seen as a barrier to recovery for those with co-occurring disorders (c). As one participant explained to me during participant observation when discussing his financial situation "money can't buy you happiness, but it can buy you security. You don't have to worry about paying for bills or buying food… stress is a killer." Indeed, the mental health charity MIND has called for the removal of the threat of sanctions for those with mental health problems owing to its negative impact on mental health and mental disorders (MIND, 2017). Equally, a recent longitudinal study found that sanctions were ineffective at motivating claimants to seek work, and "routinely trigger profoundly negative personal, financial, health and behavioural outcomes", including increased stress, anxiety and depression (Welfare Conditionality, 2018, cited in: Butler, 2018). Additionally, a number of participants remarked to me during participant observation that they sometimes have to resort to pay-day loans in order to cover unexpected expenses as their benefits do not provide any leeway in this regard. This is troubling, given that debt has been highlighted as a barrier to recovery (Best *et al*., 2016b) and there is a significant link between debt and suicide (Bond and Holkar, 2018).

Emily also articulated her negative experience with the DWP. She described having her Personal Independence Payment[41] (PIP) revoked and, as a result, having to go to court to fight for its reinstatement. She believed this was a primary factor in why she relapsed and associated the experience with a decline in her mental illness:

> "Well I think that's why I relapsed because that was stopped. My ESA [Employment Support Allowance] got cut right down too. I was trying to pay bedroom tax as well and my ESA was cut down because I had to come off DLA [Disability Living Allowance], and obviously appealing the PIP. So, I think that's why I relapsed and had to go in [for detox] in that October. Because I was just struggling and struggling, and I couldn't pay the rent and it [her mental illness and substance use] was… getting bad again. Then when I was awarded my PIP back then, I obviously had my ESA put back up so I can manage better now."

Similar to Keith, Emily suggests that the financial implications of losing one's benefit is a significant source of stress and indicates that this had a negative impact on her mental illness,

[41] The Personal Independence Payment (PIP) is a financial benefit awarded by the Department of Work and Pensions to those who suffer from long-standing health problems or disabilities

and was a crucial factor in her relapse. This seems to support the view that stressful experiences, particularly concerning finance, are a significant barrier to recovery for those with co-occurring disorders (c). Moreover, Emily states that once her financial situation improved as a result of being re-awarded her PIP, she was able to "manage better", suggesting that Emily's relapse was a direct consequence of having her benefit revoked, and that her drug use was an attempt at managing her mental illness, which was exacerbated by the stress. It also suggests that financial security can improve resilience and therefore lead to better mental health. This resonates with the concept of recovery capital, in particular, the physical capital[42] aspect of it (Cloud and Granfield, 2009), and supports the notion that recovery resources (such as those described in the recovery capital model) are "mutually reinforcing, dynamic and self-perpetuating" (Neale, Nettleton and Pickering, 2014: 10) and that that improvements in one domain of recovery capital (i.e. physical capital) will lead to improvements in other domains (i.e. mental health, an element of human capital) (Hennessy, 2017). Given the consistently highlighted significance of financial and human capital in the recovery process (Hennessy, 2017), the financial hardship associated with disruptions in benefits would seem to be a significant barrier to the recovery process of service users with co-occurring substance use, anxiety and depression.

The Negative Impact that Surviving on Benefits has on Anxiety and Depression

Poverty is consistently cited as a risk factor for suicide (Wyllie *et al*., 2012), substance use, poor mental health and mental disorders (Marmot *et al*., 2010; NICE, 2016). The adversity associated with poverty has also been linked with relapse in those with co-occurring disorders (a) (Harris, Fallot and Berley, 2005). Descriptions of the poverty associated with receiving ESA were also evident in the current study, as Edward explains:

> "Sometimes I do have difficulty stretching it from one payment day to the next. Um, but I'm alright you know. Um, if I've run out of food, there's a place in Raven Hill, where I can go and get free food. It's not always the food I *like* [emphasis of participant], but it's food. You know, and if I run out of bus fare, luckily I'm quite fit so although I live four, five miles away um, walking back and forth that distance doesn't bother me"

[42] Physical capital refers to tangible assets an individual may draw on to help sustain their recovery, for example, financial stability and adequate housing

Edward explains that he often finds it difficult to stretch the money he receives from ESA over the month, and sometimes has to rely on foodbanks to survive. He also states that he sometimes does not have enough money to get the bus to the treatment centre from his house, and has to walk the four/five-mile journey instead. While he states that this does not bother him, this kind of problem may hinder engagement in treatment for those who are less able. Vaughn also articulated this point, and voiced his frustration at the little money he receives:

> "This no working malarkey is crap. I hate it. I do hate it. You know, I've always been a worker. So, me not working is not helping things [mental health] at all." … "'cause you've no money, 'cause I'm on such a *pittance* [emphasis of participant] of benefits, like three hundred quid a month."

Vaughn states that he has "always been a worker" and hates not being able to work, as it negatively impacts on his mental health, which suggests that Vaughn perhaps feels unproductive as a result of being unemployed. However, he goes further to indicate that the inadequacy of the support he receives from the DWP is also having a negative effect on his mental health, as he is on "such a *pittance* of benefits", that leave him well below the poverty line, which may detract from his ability to feel self-sufficient and negatively impact upon his mental health. This lends support to previous research that has identified a link between poverty and adverse mental health (Marmot *et al*., 2010; Wyllie *et al*., 2012) and suggests that feeling self-sufficient is an important facet of good mental health. Moreover, Vaughn's response implies that the financial hardship associated with being on ESA may put pressure on him to return to work.

Similarly to the responses of Keith and Emily, the responses of both Edward and Vaughn emphasise the important role of adequate physical capital in the recovery process. For Edward, improvements in this domain would help him avoid food banks and gain access to local transport links[43] to and from the treatment centre. Whereas Vaughn, similarly to Keith

[43] The availability of adequate transport links has been classified by some authors (Collinson and Best, 2019) as an element of community or collective capital (an overarching element that subsumes the cultural capital category purported by Cloud and Granfield (2009)), and an important factor in improving recovery prospects by,

and Emily, emphasised the impact that poor financial stability has on his mental health, once again highlighting the interconnectivity between the different elements of recovery capital (Hennessy, 2017). These responses are important to emphasise as it seems that the benefit system itself negatively impacts on the cultivation of recovery capital, which has been shown to be an effective method of measuring recovery (Collinson and Best, 2019), through limiting gains in physical capital.

The Conflicting Employment Perspectives of the Job Centre and Substance Use Treatment

Discussions with service users during participant observation highlighted that as the those in treatment are often out of work in order to focus on their recovery, the vast majority rely on the support of the benefits system. However, many found this a difficult situation to be in and disliked having to rely on it. This was primarily due to the financial hardship associated with it, as Christopher mentioned:

> "I'm lucky [to have] my work coach, because legally, I'm supposed to be looking for work 35 hours a week to get Universal Credit, even though I don't really want to go to work, and my work coach has said, 'You're not ready to go back to work'. She said 'It's way too early, give it at least six months', [and] I said, 'Well they told me 18 months'. She said 'Well, see how you do in 6 months'. I mean, I'm not trying to say I'm not going to go back to work for a year and a half, I know I'll probably get a job after Christmas… because it's a means to an end, isn't it? I can't continue to live… on benefits, because it is depressing and if… Because the depression does come a lot from not being able to do things you feel like you need to do, or, not so much that you'd like to do but… you should be doing. Especially for your children, or for yourself as well" … "I mean you should be grateful that you've got a roof over your head and everything. But when you can't afford to take the kids out on a weekend, or you can't afford to go out and buy a new pair of shoes."

Christopher explains he is "lucky" to have a work coach who is sympathetic to his situation, and does not pressure him to return to work or sanction him for not doing so, as he doesn't feel ready to return to work, suggesting this requirement may be damaging to recovery prospects. However, Christopher's response articulates a point that was put forward by a number of service users, which is that substance use treatment and the DWP have conflicting

for example, improving access to treatment services and helping service users to reintegrate themselves within dominant social behaviours.

views on employment, specifically, regarding when a service user should return to work. As Christopher states, he is required, under the regulations of Universal Credit, to be searching for work for 35 hours a week. If his work coach had not been sympathetic, he would have had to prove this during his regular meetings at the Job Centre. However, as he explains, he has been advised by the treatment service not to return to work for 18 months. This is clearly problematic, as being sanctioned for following the advice of treatment agencies creates a clear barrier to recovery. Yet, Christopher indicates he will seek work before the advised period as the financial limitations of Universal Credit are "depressing". Christopher's response implies that he feels ashamed that he is not able to afford basic necessities like a pair of shoes, or to do things he should be able to do, such as taking his children out for the weekend. He also implies that this is a primary driving force of his depressive symptoms. This provides corollary evidence to support the statements cited above, which suggest that the financial implications of relying on benefits exacerbate mental disorders, deteriorate mental health, and may force service users back into work before they are ready. It also highlights again the significance of the physical capital in the recovery process and the importance of improving support in this area (Cloud and Granfield, 2009; Best and Laudet, 2010; Hennessy, 2017). Moreover, Christopher's response indicates that the value of physical capital in recovery may stem from its impact in reducing the consequences of financial instability on anxiety and depression, signifying the interwoven relationship between mental illness and drug use.

Christopher went on to explain that he does not think the benefit system understands the treatment process for substance use, and states that they see the issue of employment as very "black and white":

> "I think the benefit system needs to change, because they've got no understanding of what WCADA and Cyfle Cymru are doing to help people. They just see it in black and white: 'Oh, if you're off your medication and you're not in treatment, you should go straight back to work.' 'Well hang on, the treatment centre told me "Don't go back to work. It's not advised"'."

This statement by Christopher again articulates the frustrating situation many service users find themselves in when trying to juggle the conflicting views the Job Centre and treatment

services have on employment. The DWP seems to be unaware of the longevity of the recovery process for many service users.

Christopher's point about DWP having "not understanding" of the work of WCADA and related substance use treatment organisations is notable, as a similar point was made by Owen. Owen is employed full-time as a peer mentor and like many other service users who become peer mentors, he began as a volunteer. Before he got the job, Owen relied on Universal Credit to survive, and recalled his experience with the Job Centre:

> Owen: "I'd volunteered, at that time, 9-5 Monday to Friday, apart from the odd day off and stuff, for like a year. And that was with the Job Centre sanctioning me, um, relying off the kindness of my friends and family to feed me."
>
> Interviewer: "So how come the Job Centre were sanctioning you?"
>
> Owen: "They were sanctioning me because they didn't feel that me volunteering was helping me become more employable."

As will be discussed further in Chapter Six, volunteering often provides an important stepping stone toward paid employment and can be an important facilitator of recovery for those with co-occurring disorders (a) (NICE, 2016). Indeed, this is a common pathway for service users who become Peer Mentors (Maguire, Holloway and Bennet, 2014). However, Owen explains that the Job Centre repeatedly sanctioned him over his volunteering work, believing it was not improving his employment prospects. Given how common the volunteer-peer mentor pathway is, and how valuable becoming a peer mentor can be for maintaining recovery (Maguire, Holloway and Bennett; see also: Chapter Six), this indicates that the Job Centre and its attitude regarding volunteering may represent as a barrier to recovery for those with co-occurring disorders (c).

Implications for Recovery

The evidence presented in this chapter suggests that relapse often occurs in response to situations which induce negative thoughts and feelings, suggesting that drug use is a coping mechanism for managing adversity in the absence of more positive coping strategies. As Emily noted:

> "But it is scary every day, because it's a battle every day. Trying to… stop going back into that… way of dealing with things."

Emily stated that every day is "a battle" to avoid going back to that "way of dealing with things", suggesting that Emily's substance use was one way she found of coping with adversity. Thus, it would seem that treatment would benefit from helping service users develop resilience to stressful situations given their association with exacerbated mental disorders and relapse (Sinha, 2008; Alim *et al*., 2012), and develop strategies to manage them without resorting to substance use. Indeed, this was highlighted by Owen:

> "All the reasons I was using drugs started to disappear as I became more structured and capable to deal with things."

This suggests that once service users begin to develop skills to respond positively to adversity, their drug use may subside. Therefore, building resiliency among service users may be an important element to consider within treatment and recovery for those with co-occurring disorders (c) (Alim *et al*., 2012; Strang *et al*., 2017). Indeed, developing skills to better cope with adverse experiences is one of the key aspects of human capital in the recovery capital concept, and therefore the current research supports the importance of cultivating human capital in recovery (Cloud and Granfield, 2009; Neale, Nettleton and Pickering, 2014). Owen also notes that structure played a pivotal role in his recovery, which is something that is discussed in more depth in Chapter Six.

Conclusion

Following on from the previous chapter, which highlighted mental illness as a facilitator of drug use, the current chapter suggests it is also a prominent factor in relapse. Service users noted that feeling isolated, stigmatised and stressed all exacerbated their anxiety and depression, and often facilitated relapse as a result. Therefore, simultaneous treatment of both conditions seems necessary and may best be served (as discussed in Chapter Three) through integrating mental health and substance use treatment. Additionally, the cultivation of human capital in the form of developing positive coping strategies seem a vital element in the recovery process (Cloud and Granfield, 2009; Neale, Nettleton and Pickering, 2014).

Service users also mentioned that interaction with drug-associated friend groups, and the isolation associated with distancing themselves from them were a risk factor for relapse. This suggests that treatment would benefit from promoting socialisation between service users to encourage the development of new, recovery-oriented social networks. This is discussed in more depth in Chapters Five and Six. The implications of maintaining contact with actively-using social networks detailed in this chapter also highlight the importance of cultivating social capital in recovery (Best and Laudet, 2010), something that is also discussed in greater depth in the following chapters.

Finally, this chapter has suggested that the DWP is a significant source of stress for many service users, and their relationship with it often exacerbates their mental disorders and worsens their mental health. The financial implications of being sanctioned, losing one's benefits, and the general inadequacy of the financial support they receive all had an exacerbatory effect on service users' disorders. These findings lend support to previous research that has highlighted the importance of financial capital in recovery (Cloud and Granfield, 2009; Hennessy, 2017) and suggest that the inadequacy of the benefits system in supporting those with co-occurring disorders (c) is a potential barrier to recovery. Additionally, some service users discussed feeling dismayed at having to contend with the conflicting employment perspectives of the DWP and substance use services. Participants described feeling pressured to return to work before they were ready, contrary to the advice

of their treatment agency. Moreover, the DWP's stance on volunteering was also highlighted as problematic, especially considering the fact that the service user-volunteer-employee pathway is common within substance use services (Maguire, Holloway and Bennet, 2014).

Chapter Five: The Role of DOMINO in Reducing Substance Use and Improving Mental Health

Chapter Three and Four highlighted that mental illness and substance use seem intrinsically connected. In Chapter Four, isolation, boredom and reengagement with drug-oriented friend groups were identified as barriers to recovery given their association with relapse. This suggests that treatment services would benefit from directly addressing these barriers through promoting the cultivation of social capital. Social support networks that are supportive of recovery are an invaluable resource in sustaining recovery and can "enhance social connectedness by providing the opportunity for the sharing of resources, information, social support, and may reinforce behaviours that facilitate recovery and sustain motivation for change" (Best, McKitterick, Beswick and Savic, 2015: 272). This chapter examines the DOMINO project and describes its efficacy in promoting recovery by cultivating social and human capital through encouraging socialisation and engagement in structured, positively-reinforcing, meaningful activities in a communal atmosphere.

The DOMINO Project, an acronym for the 'Development Of Motivation In New Outlooks', does not directly treat substance misuse behaviour but instead provides an opportunity for service users to participate in constructive, pro-social activities with a group of their peers in a supportive but informal environment. In this sense, it functions as more of a recovery group than a treatment service. This project may help address feelings of isolation and boredom, improve mental health by focusing on wellbeing, and encourage service users to develop new support networks of recovery-oriented peers, which become an important source of hope, optimism and motivation. As mental health and mental illness are correlated entities, interventions such as DOMINO that seek to improve an individuals' mental health may also lead to a reduction in anxious and depressive symptoms.

The regularity of DOMINO activities may also help provide structure and routine to the lives of service users, who, as this chapter will suggest, are left with vast amounts of free time which would otherwise have been spent in drug-oriented behaviour. Filling this newly-found free time with constructive activities, such as gardening or music, may help to avoid

relapse and build self-worth. Additionally, by focusing on the mental health of service users, DOMINO seems to make engaging with treatment an appealing prospect and may improve treatment retention and the mental health of service users as a result.

"You don't know a bigger bully than yourself": The Importance of Alleviating Loneliness

As discussed in the previous chapter, isolation seems to be a substantial barrier to treatment. Not only can it precipitate relapse (Alverson *et al*., 2001; Laudet, *et al*., 2004; Christie, 2017), but it is also associated with an increased risk of depression and anxiety (Rokach, 2005; Marmot *et al*., 2010; Hidaka, 2012) and a heightened negative thought process in depressed people (Gilson, Freeman, Yates and Freeman, 2009). Emily described how being alone in her flat precipitated feelings of craving and emphasised the role the treatment centre plays in addressing her isolation through providing her with an opportunity to leave her house:

> "If [daughters name] is working and… that's when… and my other daughter works on a Thursday or Friday… so if they're not there and I'm there on my own, that's when my head starts overthinking then and starts thinking then 'Right okay, go get a drink now then.' And I get so scared, and then I think 'No, no, no'. But that's why I do need to… keep coming [to treatment] to get myself out of the flat."

Service users are highly susceptible to loneliness given that many will have distanced themselves from former, drug-oriented social circles once they enter treatment. Every participant throughout this study acknowledged that they had to alienate themselves from their old social circle once they entered treatment. This is a difficult but necessary task for those who wish to progress with recovery. As discussed in Chapter Four, maintaining contact with peers who still engage in drug taking activity creates barriers to successful recovery, as Katherine noted: "My friends… if I go back there, I'm using". However, this process may be one of the most challenging aspects of the recovery process, given that service users often developed these social circles when they first began using drugs in their adolescence:

> "I've had to distance myself from 90% of the people I used to hang around with when I used. Unfortunately, or you know… fortunately/unfortunately, um, some of them were friends you know, that I've known since I was this tall [gestured a height you'd

> be when you were a child], so you know, primary school sort of age when I first moved to Swansea."

Entering treatment meant that Morgan felt the need to ostracise himself from his prior social network, many of whom he had known for over 30 years. This represents an onerous task for those who wish to progress with recovery and one which participants of other qualitative studies have described their reluctance to complete, as noted by a participant in an American ethnographic study: "I can't give up friends to stay sober" (Alverson *et al.*, 2001: 11).

Christopher echoed Morgan's response:

> "You've also got to remember, that when you come into treatment, you, you… you've got to change all your friends, all your associates. So, the only other people you can bond with, are people in meetings [AA meetings] or… and it just so happened that a lot of people I was getting on with in meetings, were people I knew from treatment or people I'd met in WCADA."

Christopher highlights that entering treatment means leaving behind an old way of living, and all of the people associated with it. As Alverson and colleagues (2001) state, "to stop using is to change one's life" (p. 11). Distancing oneself from old friends to enter treatment and progress with recovery can create a void of social connections, which can lead to feelings of loneliness (Mercer and Woody, 1999) highlighted previously as a predictor of relapse. However, treatment and recovery groups have the potential to fill this void and address isolation. As Christopher mentions, the "only people you can bond with" are those who you interact with during recovery groups or treatment, suggesting that the opportunity to socialise with other service users is an important part of recovery for service users, as many have removed themselves from substance-associated social circles. This lends support to previous research from Best and colleagues (2013) who highlighted that engagement in meaningful activities with other service users provides the opportunity to avoid risky behaviours associated with substance use, build new social-networks of peers not associated with drug use and to improve their self-efficacy and self-esteem[44] in the process. As such, treatment services may benefit from following WCADA's approach in facilitating socialisation

[44] The benefits of DOMINO in developing the self-efficacy and self-esteem of service users is discussed later in the chapter

between service users through recovery programmes such as DOMINO so that they may develop new, recovery-supporting social networks. Indeed, previous qualitative studies have found that treatment approaches that neglect social relationships will fail to engage service users with co-occurring disorders (a) (Alverson *et al*., 2001). Furthermore, the Government guidelines for treating substance misuse state that people "evaluate and change their substance use behaviour with reference to prevailing social norms" and suggest that promoting interaction and socialisation with peers in recovery may be an important mechanism by which to facilitate behaviour change (Strang, 2017: 54). Promoting opportunities for socialising with peers in treatment and recovery would also help service users cultivate valuable social capital, which in turn, can aid the development of human capital as service users in recovery often share encouragement, hope and coping mechanisms with one another. Social capital is a crucial factor in building and developing the pools of both community and personal resources necessary for sustaining recovery (Best and Laudet, 2010; Best, McKitterick, Beswick and Savic, 2015) and is discussed in greater detail in following section of this chapter and also forms a large part of the discussion in Chapter Six.

The crucial role that social interaction with other service users played in the recovery process was perhaps the most prominent theme during this study. Owen articulated the importance of socialisation with peers whilst discussing why he valued attending the DOMINO allotments:

> "Being at the allotments… Like, they're beautiful and it's nice, and then when you're there, there's peer-led support as well; whether you're offering that support or receiving that support. Um, just having a laugh, socialising, interacting with other people. Socialising actually, I hadn't mentioned that. Socialising is *huge* [emphasis of participant]. Because the alternative when you're in that state is isolating. And… you don't know a bigger bully than yourself, because you know all your buttons."

Supporting evidence from the previous chapter, Owen describes the impact isolation has on his mental health. He states that being alone was problematic as "you don't know a bigger bully than yourself", suggesting that being isolated led to an increased negative thought process and rumination, which was highlighted in Chapter Four as a predictor of relapse due to its exacerbatory effect on anxiety and depression. Owen also emphasises the "*huge*" role socialisation played in his recovery, which suggests that the socialisation promoted by the

DOMINO project was a key aspect in addressing the problems exacerbated by isolation. This sentiment is supported by a recent publication from Public Health England which stated that organisations and groups that provide opportunities to reduce isolation play a "crucial role in enabling and sustaining recovery" (Christie, 2017: 34). Moreover, Owen highlights the beneficial role of peer-led support, whether he was offering or receiving it, again highlighting the importance of cultivating social capital during recovery (Best and Laudet, 2010).

Best and colleagues (2013; 2015) highlight engagement in meaningful activities as an important aspect in cultivating recovery capital and define these activities as those involving education, training or employment and suggest these are valuable in improving wellbeing and quality of life. However, a recently conducted systematic review of the Recovery Capital literature identified a gap surrounding research that engages qualitatively to understand the recovery process of service users and identify what other pro-social opportunities besides employment and education may lead to a maintaining a healthy life in recovery (Hennessy, 2017). This current research seems perfectly placed to address this gap and suggests that programmes such as the DOMINO project are effective at improving wellbeing and quality of life, as well as reducing symptoms of anxiety and depression[45]. The DOMINO project and the activities it offers, may therefore be considered an example of 'meaningful activity'. The DOMINO project offers a variety of regular, constructive, pro-social activities for service users to engage with together throughout the week, such as music and cookery lessons, gardening and structured walks, and helps WCADA promote socialisation and develop a community atmosphere[46]. The project is valued highly among service users and received praise from every participant who engaged with it. As Owen stated: "I think the support that DOMINO can offer is immeasurable for people's recovery". Indeed, when asked what service users would change about their treatment, the most frequent response was the desire for more funding to support the project, which had recently been significantly scaled-down due to loss of a National Lottery subsidy. As this section has highlighted, the DOMINO project plays a key

[45] For example, by reducing isolation and therefore the rumination associated with it

[46] In this sense, DOMINO offers the "therapeutic community" intervention that Marmot and colleagues (2010: 143) highlighted as one of the most effective methods of substance use treatment in their extensive report on reducing health inequalities for the UK Government.

role in helping service users to cultivate social capital through promoting socialisation between service users. The notion of social capital is expanded upon in the following section.

"We talk about recovery, we share experiences, we socialise": Encouragement and Hope through Supportive Relationships

Social support is "consistently highlighted" as a critical factor in sustained recovery, especially among former alcohol users (Best, McKitterick, Beswick and Savic, 2015: 272) and therefore, the supportive element of DOMINO highlighted in the previous quote from Owen is important to consider, as a number of other participants discussed it. While the project offers both formal support and informal support, the informal support element was consistently emphasised as playing a key role in the recovery process suggesting its efficacy in assisting service users to cultivate social capital. Whilst discussing the role DOMINO had played in his recovery, Christopher remarked:

> "I think it's been important not just in my recovery, but for WCADA as a whole, because if [WCADA] wants to get people through Primary Treatment, if people start going to DOMINO and meet people who've been through treatment, then they can see what it's done for them and it'll give them encouragement and hope."

Christopher's response suggests that the socialisation with other service users prompted through the DOMINO project is an important source of motivation for those who have recently entered treatment. This supports research from Harris, Fallot and Berley (2005) who, through their own qualitative interviews with female service users with co-occurring mental disorders (a) in the US, found that those who had been through treatment become role models for newer service users who valued the guidance and support of someone who had "walked in [their] shoes" (p. 1293). This resonates with the concept of the 'wounded healer' and is discussed in more depth in Chapter Six. Moreover, Christopher's word "hope" to describe the effect of socialising with recovering peers is notable, as the establishment of hope has been highlighted as an "essential" aspect of the recovery process in previous literature reviews (Drake, Mueser and Brunette, 2007: 133) and qualitative studies (Laudet *et al*., 2004) of those with co-occurring disorders (a). Indeed, Public Health England guidelines for treating those with co-occurring disorders (a) described encouraging hope as a "vital part"

of supporting those with co-occurring disorders (a), and suggested treatment should encourage interaction with others with lived experience of recovery (Christie, 2017: 34). In addition, recovery does not only require behavioural change but also (perhaps more importantly) lifestyle change, in order to be effective (Melemis, 2015; Groh, Jason and Keys, 2008). Christopher suggests that engaging with DOMINO and seeing what recovery has done for other service users, how it has improved their life, may encourage others to continue and adopt the lifestyle changes necessary to sustain recovery. This resonates with literature from recovery groups such as Alcoholics Anonymous, which found that the social networks that are developed in recovery are important not just in reducing substance use but in promoting and encouraging the idea that it is the adoption of a healthy lifestyle, not just the removal of a negative behaviour (substance use) that is important and conducive to recovery (Groh, Jason and Keys, 2008).

Connectedness, hope, identity, meaning and empowerment (CHIME) have emerged in both the substance use and mental health fields as central tenets of successful recovery (Best, De Alwis and Burdett, 2017). Although these themes were originally identified in the context of mental health research (Leamy, Bird, Le Boutillier, Williams, and Slade, 2011), they fit well within the substance use recovery sphere as recovery capital and therefore, recovery prospects, are enhanced when individuals develop a sense of CHIME (Collinson and Best, 2019). CHIME is critical to how recovery operates and is sustained (Leamy *et al*., 2011) and Christopher suggests that socialisation promoted through the DOMINO project may be an effective tool to enable service users to develop a sense of CHIME as he mentions that the cultivation of hope and motivation for recovery is particularly mediated through socialisation with other service users in post-treatment[47], who are in recovery ("if people start going to DOMINO and meet people who've been through treatment, then they can see what it's done for them and it'll give them encouragement and hope"). Given that the absence of motivation and hope are central tenets of depressive (Jacobson *et al*., 2001) and co-occurring disorders (a) (Mueser *et al*., 2003), the current study suggests that communal, activity-based and

[47] However, engagement with those who had not formally progressed through treatment was also highlighted as beneficial (for example, during therapy groups) and is discussed in greater detail in Chapter Six.

positively reinforcing activities with peers in recovery are an effective way of building these qualities.

The new social circles that develop through treatment and recovery become informal support networks for service users and offer a "powerful alternative" to those associated with drug taking (Harris, Fallot and Berley, 2005: 1293). Therefore, these social support networks play a valuable role in the recovery process of those with co-occurring disorders (a) (Drake et al., 2001). Christopher went on to explain why this was the case:

> "We've all been in recovery, I mean [Service User (SU) name] hasn't been through the Twelve Steps *yet* [emphasis of participant], but I know [SU name] has a few times. And… yeah, we, we, we talk about recovery, we share experiences, we socialise. It's better you know, because I think otherwise, if you haven't got a network of people, you're gonna' be isolating yourself. If the only thing you've got to look forward to in your life is going to a couple of meetings a week, what's going through your head at home? Do you know what I mean?"

There are a number of important elements to consider in Christopher's response. Firstly, Christopher emphasises the importance of socialising with other service users, explaining that "building a network of people" is important to avoid isolation. He describes that socialisation with other service users provides the opportunity to share experiences and provide support to one another regarding recovery. This suggests that building an informal support network of peers who are also in recovery is an important aspect of successful treatment for those with co-occurring disorders (c), a conclusion that supports other research on those with co-occurring disorders (a) (David and O'Neill, 2005; Murthy et al., 2016). It also emphasises the important role that social capital plays in recovery (Cloud and Granfield, 2009; Best and Laudet, 2010) and suggests that social capital also aids the cultivation of human capital. A finding that is consistent with previous research that has highlighted the interconnectivity between the various tenets of recovery capital[48] (Hennessy, 2017). Secondly, supporting evidence provided in the previous chapter, Christopher highlights isolation as a risk factor and correlates it with an increase in negative thought processes (i.e. "what's going through your head at home?"); highlighting once again the interrelated relationship between negative

[48] i.e. social capital, human capital, physical capital and community capital

thought processes and substance use, which is exacerbated during isolation. Finally, he discusses the value of having something to "look forward to" in treatment, suggesting the important role that meaningful, diversionary activities can play in successful recovery through providing positive reinforcement; a conclusion which is consistent with previous research from the US (Laudet, Magura, Vogel and Knight, 2004; Davis and O'Neill, 2005; Drake, Wallach and McGovern, 2005).

In contrast to the accounts of other service users, Katherine believed that building a social network of peers to socialise with outside of treatment was not beneficial, as she wanted to be able to move on once treatment had concluded. When asked if she had made any friends within treatment she stated:

> "I've met loads of people here, yeah. I haven't taken anyone's number and stuff like that, just because... I dunno, I think it… it would keep me here, longer than… I suppose I'd… want to be"

One factor that may explain this departure from the predominant view of other service users was that Katherine was in a relationship and therefore not isolated, and perhaps less inclined to covert social relationships as a result. However, it does raise a question regarding whether developing friendships within treatment may prevent service users from progressing past the treatment sphere. Nevertheless, her response suggests that it may be appropriate to encourage service users to engage in community work outside of the treatment centre to help build alternative, pro-social support networks that do not revolve around substance use treatment or recovery groups. Indeed, many service users expressed a desire to engage in volunteer work (See: Chapter Six), which may offer service users the opportunity to diversify their social network beyond the recovery sphere.

"Structure is super important because it stops your mind thinking overtime": Using Structured Activity to Replace Old Routines

Socialisation with other service users is not the only beneficial feature of communal, activity-based interventions. As the current study and previous qualitative research has highlighted,

feelings of boredom and isolation are common among service users with co-occurring disorders (c), and present as risk factors for relapse (Laudet, Magura, Vogel and Knight, 2004; Davis and O'Neill, 2005; Harris, Fallot and Berley, 2005) and therefore a barrier to recovery. As will be discussed below, time-tabled, diversionary activities may go some way to address this by helping service users structure their days and replace old routines based around drug use with those associated with recovery.

Substance use has often been the central element in the daily routine of service users for many years (Mueser et al., 2003). Therefore, many of those who enter treatment do so with a void of time that would have previously been spent engaging in drug-oriented behaviour (Mercer and Woody, 1999). The current research highlighted a similar finding, as Morgan explains:

> "Once you get into the physical habit, you spend so much time sort of chasing the drug anyway; and you spend so much time just… going through the motions of taking it and, you know, if you're smoking um, heroin, you've got to spend, before you go out in the mornings, you've got to get up… about an hour earlier, so you can spend half an hour smoking enough so that that will then last you until… the next time you'll be able to use, which could be in the evening, or whatever. It's a full-time job almost. I know that's, you know, that's another cliché really, but it is a full-time job, so you're left with a lot of spare time when you do give up."

As highlighted above, drug use becomes an engrained element in the daily routine of substance users and much of their time is structured around it. Morgan's analogy comparing the time spent in drug-oriented behaviour to a full-time job is striking as it emphasises the amount of free time that becomes available to service users once they cease their drug use. This, coupled with alienation from an old substance-associated social networks, leaves service users at a heightened risk of boredom and loneliness, both of which are risk factors for relapse. Indeed, an excess of free time has been highlighted as a risk factor in relapse for those with co-occurring disorders (a) (Sacks, Reis and Ziedonis, 2005). This suggests that treatment services would benefit from helping service users structure their time around alternate, drug-free activities, such as those offered by the DOMINO project and to develop new daily routines based on these. Indeed, Morgan went on to highlight that the DOMINO project helped him structured his time:

> "I come here fairly often at the moment. I almost sort of feel like it is a bit of a job you know in… in a certain way. I sort of treat it like that to… keep a timetable really."

DOMINO seems to help service users incorporate structure into their daily lives through a weekly timetable of activities. In this way, DOMINO and other such meaningful activity programmes can help service users who do not feel ready to return to work (a primary source of routine and structure in society) to develop routine and implement structure. Morgan's perspective that attending treatment is "a bit of a job" is also notable, especially given his previous assertion that his drug use felt like "full-time job". It emphasises the amount of time required for recovery and suggests that, contrary to the belief of the job centre, employment may be an unrealistic expectation for some service users in the early stages of recovery. However, an excess of free time[49] is a daunting aspect for many service users, even after they have completed their treatment:

> "I was worried that when I came out of primary treatment, I didn't know what I was going to do with my time and the last thing I wanted to do was just rush straight back into work. So, it was like, 'well, where do I go from here?'"

This excerpt came from a discussion in which Christopher was explaining the value he placed on the opportunity to "do something positive" provided by the DOMINO service. As Christopher mentions, the "last thing" he wanted to do was rush back into employment and he therefore valued the time he could spend in DOMINO. As will be discussed further in Chapter Six, many service users in the current study described feeling 'unready' to return to work. Therefore, DOMINO and other meaningful activities, may represent a constructive way to avoid the isolation and boredom associated with unemployment. Furthermore, Christopher's uncertainty over the future seems problematic for him. This suggests that service users with co-occurring disorders (c) would benefit from significant aftercare, wherein options for the future are discussed.

[49] The availability of so much free time would seem to contrast with the requirement to undertake 35 hours a week of active job searching to receive Universal Credit from the DWP. However, as Christopher mentioned in Chapter Four (p. 107) he was "lucky" to have a work coach who did not vehemently enforce this requirement, as he was not ready for work. This suggests that some work coaches acknowledge that spending so much time searching for employment before service users are ready for it, may damage recovery prospects. This is discussed in greater depth in the following chapter.

Owen also expressed the value of using treatment and recovery groups such as DOMINO to structure their time, as Owen explains:

> "[*coming into treatment*] gave me the structure that I was clearly craving. I found myself going to uh, the DOMINO allotments. I hate gardening. But I found myself going there and just being, all of a sudden, I was encouraging other people. It hadn't been something I thought about, it was like… 'Oh believe me, like, I can't get up in the morning either but look I'm here. If I can do it, you can do it.'".

In addition to supporting the positive role that structure and meaningful activities can play in the recovery process, Owen also provides an example of service users offering both encouragement and hope to one another; highlighting the informal support networks that develop through programmes such as DOMINO. As is discussed previously by Christopher, sociable diversionary activities like DOMINO seem to foster peer-support, cultivate social capital (a crucial part of recovery for service users, as will be discussed further in Chapter Six) and encourage service users to motivate one another. He also describes that in spite of "hat[ing] gardening", he still enjoyed frequenting the allotments as they provided him with structure, but also perhaps as they were an important form of socialisation with other service users in recovery; a point he raised previously in this chapter, emphasising the importance of social capital in recovery and the efficacy of programmes such as DOMINO in cultivating it.

Owen went on to explain why structure was important to him:

> "Structure is super important because it stops your mind working overtime, and uh, just going um, off on really self-destructive tangents. Um, and it helps with that value, that self-value as well. You're actually doing something. You're being productive."

Owen states that structuring his time helped prevent his mind from "working overtime" and becoming "self-destructive". This suggests that lack of structure may be associated with a heightened negative thought process in those with co-occurring disorders (c), and can lead to self-destructive behaviour as a result. Owen also notes that structure helped build his "self-value", something which is lacking among individuals with mental illness and substance use problems (Murthy *et al*., 2016). As self-esteem was raised in Chapter Three as a factor which

facilitates drug use, building self-value may be an important aspect of treatment, and Owen suggests that being productive and implementing structure may help address this. Previous qualitative research from the US found that an effective way to build self-value in service users with co-occurring disorders (a) was through involvement in enjoyable activities (Drake and O'Neil, 2005). The current study suggests that services such as DOMINO can improve self-worth by providing daily structure and the opportunity to engage in drug-free activities that provide positive-reinforcement.

Alongside structure, engaging with the DOMINO service may also provide a sense of purpose (something discussed in more depth in Chapter Six), as one service user mentioned to me during a seaside walk with the DOMINO project: "[these walks] give me a sense of purpose and give structure to my day. They give me a reason to get out of the house". This highlights that alongside structure, participation with DOMINO can provide service users the drive to avoid isolation and a motive to engage with treatment services. In this way, the DOMINO service and others like it, may help address the risk factors associated with loneliness and boredom highlighted in Chapter Four, whilst also improving treatment retention. In addition, given that a sense of purpose is an important factor in wellbeing (Ryff, 1989), DOMINO seems an effective tool toward improved mental health.

A number of authors have cited the significance of incorporating structure into the lives of service users (Mercer and Woody, 1999; Mueser *et al*., 2003; Laudet *et al*., 2004; Sacks, Ries and Ziedonis, 2005; McKay, 2017). Warner and colleagues (1994) found that a lack of structured activity in participants with co-occurring disorders (a) led to boredom, and an increased risk of relapse as a result (cited in: Laudet *et al*., 2004). Relapse is consistently linked with feelings of boredom (Mercer and Woody, 1999), especially among those with co-occurring disorders (a) (Davis and O'Neil, 2005; Harris, Fallot and Berley, 2005) and the current research supports this connection.

Part of WCADA's policy surrounding Primary Treatment is that those engaged with it must cease participation with the DOMINO project. They have adopted this policy to ensure that the confidentiality central to the efficacy of Primary Treatment is maintained. WCADA believes that if service users participating in Primary Treatment continue to engage with those

not involved in the treatment through the DOMINO service, they may be inclined to discuss confidential issues raised by service users during Primary Treatment.

While some service users agreed with this policy, many whom I spoke with did not, as Vaughn explained when asked how he felt about the policy:

> "Well yeah, not fucking happy *laughs*. But, thing is, like I say mate, you're here for treatment… *but*, I don't know, I mean, we're all the same, but then I think is it a good idea or not? If you're getting your activities taken away, I mean, what the fuck am I supposed to do? Boredom leads to, nine times out of ten, you're gonna' fucking do something."

In addition to highlighting the significant risk that feelings of boredom can have on successful treatment (See also: Chapter Four), Vaughn also emphasises the value he places on the activities provided through DOMINO and how unhappy he is at the prospect of having these removed. He appreciates he is at WCADA for treatment but expresses concern that without access to the activities provided by DOMINO, he may relapse as he struggles to occupy his time. Vaughn's appreciation of the DOMINO service resonates with previous research that has stressed the importance of encouraging engagement with meaningful activities in the treatment of those with co-occurring disorders (a) (Laudet, *et al*., 2004; Drake and O'Neil, 2005; Marcel *et al*., 2016; McKay, 2017). However, given the evidence provided previously in this thesis regarding the importance of alleviating isolation and boredom, promoting socialisation and engaging in meaningful activities, forced disengagement from DOMINO potentially presents a barrier to recovery and may discourage service users from engaging with treatments that prevent access to it.

Service users often resort to substances when they have no other means to fill their time (Mueser et al., 2003) and Vaughn went on to articulate this, explaining that the DOMINO activities reduce his risk of relapse by occupying his time:

> "I do the walks with you and then I do the other activity, the allotments, and then on the Wednesday I do a full day of bike ride. So, I know full well if I'm not doing that, I'll end up doing something I don't want to do."

Vaughn's response seems to support previous research conducted on young adults (Correia, Benson and Carey, 2005; Andrabi, Khoddam and Leventhal, 2017), which found that substance use can be reduced through involvement in drug-free, positively reinforcing, meaningful activities. This suggests that the aforementioned study may not be limited to only young adults. Vaughan goes further to suggest that such involvement may in fact be an integral part of relapse prevention, ("if I'm not doing that, I'll end up doing something I don't want to do"), suggesting that forced disengagement from the meaningful activities offered through DOMINO could represent a risk of relapse. Vaughn's response and the concerns he describes resonate significantly with a response given during a previous qualitative study on heroin users regarding their opinions on physical exercise (Neale, Nettleton and Pickering, 2012: 124):

> "I try not to let myself get bored. I try and have, you know, enough to do in the week to not get bored… When I do get bored, like I say, I go out and have a walk, go out for a bike ride… I won't let myself get bored, because I know that's when, you know, you start thinking [about drugs]"

Previous research has found that as well as helping to alleviate boredom, meaningful activities can also reduce depression and substance use through providing positive reinforcement from other sources besides drugs (Sacks, Ries and Ziedonis, 2005). Both depression (Jacobson *et al*., 2001; Martinez-Vispo *et al*., 2018) and substance use (West and Brown, 2013; McKay, 2017; Martinez-Vispo *et al*., 2018) reduce the availability of naturally rewarding stimuli through their associated lifestyle, leading to a lack of positively-rewarding experiences. Therefore, those with co-occurring disorders (c) should likely be encouraged to engage in structured activity to bolster positive reinforcement and improve wellbeing (Marcel *et al*., 2016).

"It opened up a new world for me": A Focus on Wellbeing

Improving psychological wellbeing and quality of life are becoming increasing important aspects to consider within substance use treatment (Hoeppner, Schick, Carlon and Hoeppner, 2019) as improvements in these areas have been associated with fewer relapses (Alverson,

Alverson and Drake, 2000; Best, McKitterick, Beswick and Savic, 2015; Zand, Shams, Shakeri and Chatr-Zarrin, 2017, cited in: Hoeppner *et al*., 2019) and increased resilience to stressful events (Alim *et al*., 2012; Hoeppner *et al*., 2019). McKay (2017) posits that substance use treatment focuses too much attention on reducing substance use, rather than employing interventions that will make the recovery process an appealing prospect. The author argues that treatment should offer a positive to replace the perceived benefits of continued drug use for mood elevation (McKay, 2017). As one participant in an American ethnographic study commented when deciding whether to give up drugs: "what's in it for me?" (Alverson, Alverson and Drake, 2000: 561). A similar sentiment is highlighted in the UK Government's treatment guidelines for substance use, which suggest that treatment should focus on helping service users develop "recovery capital", by improving self-worth, establishing a sense of purpose[50] through engagement with meaningful activities and cultivating the various elements that comprise recovery capital[51] (Strang *et al*., 2017: 236).

Improving mental health and wellbeing seem an even more important aspect to consider for those with co-occurring disorders (c) who are prone to low mood, given that negative affect was highlighted previously as both a facilitator of substance use (see: Chapter Three) and a predictor of relapse (see: Chapter Four), supporting previous research (Bradizza and Stasiewicz, 2003; Laudet *et al*., 2004; Marcel *et al.*, 2016; Murthy *et al*., 2016; Strang *et al*., 2017). Treatment services therefore, may benefit from encouraging service users to engage in naturally rewarding experiences, or as Lawford (2014: 105) describes as "healthy highs". DOMINO seems like an effective tool to achieve this, as Owen notes:

> "The DOMINO project helped my mental health a lot. Because once again, that was socialising with people, um, and at times, creating stuff. There was an art group."

Owen states that DOMINO improved his mental health "a lot" and links this improvement with the creative and social aspects of the project. This suggests that engagement with sociable, meaningful activity programmes such as DOMINO may be one method of offering a positive alternative to the mood elevation associated with drug use (McKay, 2017). This would

[50] Notably, developing a sense of purpose has been previous highlighted as an important factor in addressing feelings of anxiety and depression (Hari, 2018) and improving wellbeing (Ryff, 1989)
[51] Social, human, physical and community capital

seem to support previous ethnographic research which found that regular engagement in meaningful and enjoyable activities positively associated with recovery among those with co-occurring disorders (a), especially if the activity is sociable (Alverson, Alverson and Drake, 2000). Furthermore, while the importance of socialising with other service users has been previously discussed as a significantly important aspect in recovery, creativity has not come up before. Creativity (especially art therapy), has been highlighted in the literature as a useful element to incorporate within substance use treatments as an outlet for the emotional turmoil associated with substance use disorders (Wilson, 2003). The current research suggests that creativity may also be an important element to incorporate into the treatment of those with co-occurring disorders (c).

However, whilst acknowledging the "whole new world" that DOMINO opened for him, Edward suggests that the mental health improvements associated with DOMINO may plateau over time:

> "I think to some extent I've got used to [the DOMINO project] now, but in the beginning, it was like a new world. It opened up a new world for me. You know, I have done activities before, but it gave, it does give, a sort of extra boost to me."

Although Edward notes that engagement with the activities still improve his mental health and wellbeing, his response suggests that involvement with meaningful, diversionary activities are not sufficient on their own as a mental health treatment. Nevertheless, they would seem to be an effective intervention to run alongside other existing therapies for co-occurring disorders (c). As Morgan explains:

> "I think that the DOMINO side of things is as important, if not more important, than some of the other things that have still remained. Umm, the counselling and all that sort of stuff if very important, but unless you have things to, sort of attach it to… it can be very hard to implement some of the things that they tell you. You know, 'Bring it back to the moment' this, that, and the other. Well… this morning is a perfect example of how well, you know, there are a few people down there today who are a little bit you know, off form. And um, I'd just say to them, 'It's a Monday morning and look, we're down the beach' you know what I mean? It's just, 'Right now, things are *great'* [emphasis of participant]."

Morgan highlights that meaningful activities are most effective when run alongside other psychological therapy. Indeed, as a supplementary service, this is what DOMINO is intended to do. Additionally, he references the advice from his counsellor of being "in the moment", a central component of mindfulness practice, which has shown promising results in treating substance use (Chiesa and Serretti, 2014; Li, Howard, Garland, McGovern and Lazar, 2017) and co-occurring disorders (c) (Garland, Roberts-Lewis, Tronnier, Graves and Kelley, 2016). Morgan also suggests that using this practice, he is able to improve his mental wellbeing, through reminding himself that, in this moment, "things are *great*". This seems to support recent research that found that mindfulness practice can increase the effectivity of substance-free, rewarding activities by teaching service users to recognise and savour pleasant experiences (Marcel *et al*., 2016; Andrabi, Khoddam and Leventhal, 2017).

McKay (2017) suggests that offering pleasurable and rewarding activities may also be an effective way to improve engagement, which is particularly poor for those with co-occurring disorders (a), as they are often less likely to engage with treatment (NICE, 2016; Strang *et al*., 2017). Therefore, in addition to reducing loneliness, implementing structure and routine, and improving mental wellbeing, services such as DOMINO may also improve treatment engagement. As engagement is a "critical" element in the treatment of those with co-occurring disorders (a) (Murthy *et al.*, 2016: 39), such programmes may be considered a valuable resource for those with co-occurring disorders (c). Indeed, some service users have travelled cross-country to participate in DOMINO, as Vaughn states in this excerpt of our conversation:

> Vaughn: "Over in [place name] or [place name] there isn't anything like this, at all."
>
> Interviewer: "What do you mean, 'like this'?"
>
> Vaughn: "Like WCADA."
>
> Interviewer: "What specifically about WCADA do they not have?"
>
> Vaughn: "Like you do the walks and you do the um, activities and all the stuff like that. There's nothing like that. All you do is [12-Step] meetings over there."

This exchange between Vaughn and I during our interview highlights how attractive DOMINO is for service users seeking treatment. Vaughn's response suggests that meetings alone may not be a sufficient treatment method and that diversionary activities can play a key role in persuading service users with co-occurring disorders (c) to engage with treatment.

Conclusion

Successful treatment involves helping service users build a new lifestyle, which does not revolve around drug use (Mueser *et al*., 2003). DOMINO, and other communal, meaningful activity programmes like it, may be a useful pathway to achieve this, whist improving treatment retention and addressing a number of the risk factors associated with relapse (i.e. isolation, boredom, excess of free time, poor mental health). Regular, time-tabled activity programmes help incorporate structure into the lives of service users, which can improve feelings of self-worth, build a routine to help service users from falling back into habitual behaviour and address the significant amount of free time associated with ceasing drug use through constructive, positively-reinforcing, meaningful activities.

The communal aspect of the programme also helps address the pervasive loneliness that many service users are vulnerable to once they enter treatment and therefore offers an excellent opportunity for service users to cultivate the social recovery capital necessary to sustain recovery. The community atmosphere promoted by DOMINO was perhaps the most important to participants as it provided an informal opportunity for service users to build friendships, discuss recovery and provide one another with encouragement and hope, leading to improvements not just in social capital but in human capital also; something that is discussed further in the following chapter.

The wellbeing focus of DOMINO was also significantly important for service users. Not only did it help improve their mental health and provide an environment for them to ground some of the new skill-sets taught by counsellors, it also encouraged participation in treatment and improved retention and reduced symptoms of anxiety and depression (i.e. heightened negative thought process). Through naturally-rewarding activities in a communal

environment of peers, the DOMINO Project seems to offer a positive alternative to the mood enhancing effects of substances and makes recovery a more appealing prospect. In this respect, DOMINO and other such programmes, would seem to offer an invaluable recovery resource for those with co-occurring anxiety and depression, which can supplement other treatment interventions. As Morgan concluded:

> "They call it DOMINO therapeutic for a reason because it is, it's therapy; and it's therapy without being too in-your-face therapy, you know."

Chapter Six: Peer Support, Relatability and Giving Back

As discussed in Chapter Four, stigma presents as a significant barrier to effective recovery for those with co-occurring disorders (c) (Motta-Ochoa et al., 2017) and can have an exacerbatory effect on service users' mental illnesses. Being able to relate to those around them in treatment is perhaps a vital element of treatment and recovery for this group as it helps to reduce feelings of stigma. Relatability refers to the connection service users feel to those who they considered to have similar lived experiences to their own. For those in recovery, being able to relate to those around them is important to help address feelings of stigmatisation and promote a comfortable and non-judgemental atmosphere wherein service users can talk candidly about their experiences and problems (Pallaveshi, Balachandra, Subramanian, and Rudnick, 2014). Engaging with those who have similar lived experience is also a valuable source of social capital and can help develop human capital through the sharing of hope, advice and coping strategies.

This chapter, building on evidence provided in Chapter Five regarding the importance of socialising with recovery-supporting peers, will examine two methods of peer-led support: peer-group interventions and peer mentoring, with discussion on the benefits and limitations of both. Peer-led support seems to be an effective tool to build both the social and human capital necessary to sustain recovery, and is valuable to both those providing and receiving support. In addition to providing hope and motivation to change for service users in treatment, peer mentoring also helps sustain the recovery of peer mentors by improving their self-efficacy and self-esteem and by cultivating a sense of purpose, which are all important aspects of wellbeing and good mental health.

While service users in the current study often felt they were not ready to return to work, every interview participant (and many of those I spoke with during participant observation) expressed a desire to help others with similar experiences to their own and to engage with altruistic endeavours generally (i.e. volunteering). Given the benefits of employment on recovery (Best *et al*., 2013), pursuing opportunities that involve helping others may be a valuable method of sustaining recovery for those with co-occurring disorders (c) and therefore, treatment services may benefit from encouraging such opportunities.

"We're all in the same boat here": Peer-Led Support and the Desire to be Understood

The desire of service users to receive support from those who have had similar experiences to their own was as notable within the current study, as it has been in others (Vogel, Knight, Laudet and Magura, 1998; Laudet *et al.*., 2004; Sacks, Ries and Ziedonis, 2005; Drake, Mueser and Brunette, 2007). It is perhaps the salient rationale behind the concept of peer mentors, and sponsors in 12-step communities. Peer-support offers "a level of acceptance, understanding and validation not found in many other professional relationships" (Mead and McNeil, 2006; cited in: SAMHSA, 2017: 1) and is a powerful source of hope and motivation to change, sustain recovery and reconnect with the community (Barker and Maguire, 2017). As Sacks, Ries and Ziedonis (2005: 41) state: "support from other service users with similar problems promotes and sustains change".

Participants in the current study valued the support of someone who they believe 'understood' their situation through their own personal experience:

> "But, coming here… people *understand you* [emphasis of participant]. Not only do the workers, because most of the workers have gone through the system… they understand it. Plus, the people that are here in the groups with, and that you're having a chat with, and you become friendly with, they understand it because they've gone through it."

Nathan discussed the value he placed on interaction with those who have had similar experiences to himself and states that this shared-experience helps him feel "understood". Feeling misunderstood may relate to the social ostracism many of those with substance use and mental disorders have felt as a result of the stigma attached to these in society.

Engagement with those who, as Nathan emphasised, "*understand you*" through personal experience, who service users can relate to, seems important to create a forum wherein stigmatised topics can be discussed without fear of judgement, as Katherine mentioned:

> "We've all gone through different things, whether it's drinking, you know, any particular drug… anything. We've all been and done certain things, mental health breakdowns, having our kids taken from us, everything. We've all been somewhere on that road at some stage, so it's just nice here, you can talk about literally anything, whether it's just a day you've had today, it's brilliant. You don't feel judged."

Katherine's metaphor of the "road" to describe recovery is illuminating as it highlights recovery as a continual process or journey (Best *et al*., 2016a) and emphasises the importance of engaging with those who have been on a similar "road" to one's own. Service users in this study spoke repeatedly about the value of interacting with those with whom they could relate. They felt that this was important to feel comfortable, as they could discuss things considered taboo without fear of judgement, likely as such topics are routinely greeted with scorn or derision. This suggests that a significant reason for the appreciation of relatability is the stigma it ameliorates. As Emily notes:

> "Yeah and you can talk to… the other clients that come here too you know. I don't mind telling them that I'm an alcoholic, I find it a safe place… to come to where you can actually talk and say things and not being judged for it because, like, by other people outside, you feel like you're being judged. Like 'oh look at her, the alchy [alcoholic].' We're all in the same boat here [at WCADA]."

Emily's response indicates that it is important for service users to have an environment in which they feel "safe" to discuss taboo topics such as mental health, substance misuse or her problems with anxiety and depression. This supports previous research that found that those with co-occurring disorders (a) valued peer-led support as it meant they felt "safe" to speak "openly and honestly" about their problems (Pallaveshi *et al.*, 2014: 390). Further, Emily's concluding remark is elucidating, as her analogy of being "in the same boat" as other service users suggests that despite the unpleasant situation service users find themselves in, there is comfort in knowing those around you have had similar experiences.

This section will discuss two treatment approaches, group work and peer mentoring (of which relatability is a central component), and their role in the recovery process.

"It's nice to know you're not the only one": Group Work and Recovery

Supportive group therapy interventions, including self-help groups such as AA, are key features of substance use treatment (Mercer and Woody, 1999; Petersen and McBride, 2002; Sobell and Sobell, 2011; Sue *et al.*, 2016), and are especially important for those with co-occurring disorders (a) (Vogel *et al.*, 1998; Laudet *et al.*, 2004; Sacks, Ries and Ziedonis, 2005; Marcel et al., 2016). They not only provide an environment in which service users can share advice and discuss their problems frankly without fear of judgement (Pallaveshi *et al.*, 2014), but are a valuable tool to encourage the development of new social support networks of recovery supporting peers (Laudet *et al.*, 2004). The latter point being one which was highlighted in the previous chapter in regards to the DOMINO project as a significant facilitator of recovery. Indeed, some authors have suggested that "Peer-oriented groups are the centrepiece of dual diagnosis treatment" (Drake, Mueser and Brunette, 2007: 134), given their efficacy at promoting recovery.

The line between group work and socialisation with peers is blurred and many of the benefits overlap significantly. However, the agency provided to formalised group therapy seems to encourage and promote discussion of stigmatised topics and provides a formal setting for service users to listen and share experiences and coping strategies in a safe and supportive environment of peers. The relatability and comradery forged through shared experience meant that service users were able to discuss problems and share advice and coping strategies, without feeling shame or judgement from those around them.

Previous authors have also noted that recovery-oriented, supportive social networks and engagement in recovery groups are two critical aspects that promote and sustain recovery capital and wellbeing, and treatment services are well positioned to facilitate this (Best *et al*., 2015). Peer-group interventions offer service users the opportunity to develop new social support networks, learn new coping mechanisms (Mercer and Woody, 1999; Sobell and Sobell, 2011), and cultivate a sense of empowerment, hope (Wendt and Gone, 2018) and social pressure to change (Coco *et al*., 2019). The current study found that service users with co-occurring disorders (c) value such groups for the same reasons. As Christopher notes whilst discussing his involvement in Primary Treatment and AA:

> "It's nice to hear other people's experiences. I know, no one's recovery, no one else's recovery is going to keep me… keep me abstinent. My recovery won't [help them], but if we can take parts we need to out of other peoples' recovery, as a suggestion, or just listen to what worked for them. It gives a lot of hope, because in certain steps you can end up beating yourself up, or wallowing in self-pity or your ego could be growing huge *laughs*."

Christopher highlights that he valued the opportunity to listen to the experiences of other service users. Group work provided an environment to share coping mechanisms and encourage hope among the group. This supports previous research highlighting the importance of cultivating social and human capital in recovery (Cloud and Granfield, 2009; Best *et al*., 2013; 2015; Hennessy, 2017; Collinson and Best, 2019) and suggests that whilst recovery is an individualised process ("no one else's recovery is going to keep me abstinent"), service users appreciate a forum wherein they can give and receive advice, and that this interaction offers hope and inspiration. As such, his response resonates significantly with previous qualitative research, which found that service users valued peer-led interventions as it provided them a space where they could share experiences and coping strategies, whilst promoting a sense of hopefulness through interaction with those further along in the recovery process (Vogel *et al*., 1998; Pallaveshi *et al*., 2014). The research highlighted that peer-led groups facilitate feelings of relief among service users, who value interaction and engagement with others who have had experiences. This sentiment was also highlighted in the current study, as Vaughn stated whilst discussing his involvement with DOMINO: "It's nice to know you're not the only one".

Katherine also mentioned that group work had been a "big" help in her recovery, and spoke about the value of listening to the coping mechanisms used by other service users and adapting them to her own situation:

> "It's nice to… you know, listen to other people, their stories; you know, the little things that help them. You know, it's all those… and that's what I've learnt here, you can take things away and adapt them to your situation, and it *does* [emphasis of participant] help."

Once again highlighting the value of building social and human capital in recovery, Katherine suggests that hearing the "stories" of other service users is valuable as it allows her to adapt their experience and advice to her own recovery, perhaps as it offers some relatability. Of note in Katherine's response is the emphasis she used when discussing the positive effect of incorporating the solutions of other service users into her own life ("it *does* help"). Her emphasis underscores the value service users place on the lived experience of other service users as a source of advice and inspiration, and suggests that the sharing of coping strategies is a key aspect of peer-group interventions; supporting the findings of previous studies (Laudet *et al*., 2004; Sacks, Ries and Ziedonis, 2005; Best *et al*., 2015; Marcel *et al*., 2016; Strang *et al*., 2017). This sentiment was often raised during the Personal Development programme run at WCADA. Even though it is a 12-week rolling course discussing the same topics, no two sessions were ever the same due to the constant rotation of new service users in attendance. As one participant articulated during participant observation of the Personal Development group noted: "New service users means new insights. That's why I keep coming back to these classes". Peer-group interventions such as Personal Development therefore, seem a valuable tool in helping service users build the necessary social and human capital to sustain recovery.

Peer-group interventions are important for those with co-occurring disorders (a) as they offer service users an accepting and non-judgemental forum in which to discuss stigmatised topics (Vogel *et al*., 1998). The Personal Development programme at WCADA is one such forum, and was highly valued by those who participated in it. Personal Development is a CBT-based group run by a peer mentor, which offers education on a number of topics associated with relapse, such as stress, anxiety, anger management and self-esteem. The group is interactive, and service users discuss the related topic with one another and the peer mentor, who shares their own lived experience. Service users appreciated the opportunity to share coping strategies and discuss taboo topics without worrying about what those around them might think. As Katherine stated while discussing why she values being able to relate to those the group:

> "I find it easy to talk to everyone. I've never had to worry about what I'm saying, or what I'm thinking. So that's been really nice. And that's been with everyone; everyone

> I've met. You don't have to think 'can I tell them this? Are they gonna' judge me?' It's just easy, and it's nice to talk to people here."

Katherine's response indicates that she worries about being judged outside of the treatment centre, and feels she has to censor herself ("can I tell them this?"). As a result, she appreciates being around those with similar experiences as this relatability alleviates these feelings, and she is able to talk openly about her experiences without worrying about being judged (Pallaveshi *et al*., 2014). She went on to explain that just being able to talk to service users and staff about her problems and experiences without worrying about being judged has led to improvements in her mental health:

> "I'm managing my mental health a lot better since I've been coming here and I'm able to talk to people."

This indicates that she has been unable to talk with anyone about her problems in the past, perhaps fearing the judgement she may receive for doing so, and as such, she appreciates being able to talk to those who she knows will not stigmatise her. This supports previous research that has highlighted that engagement with recovery-oriented social support networks and recovery groups lead to improvements in mental wellbeing and help sustain recovery (Best *et al*., 2015; Collinson and Best, 2019). As poor mental health often leads to exacerbated mental disorders (which were highlighted as both a facilitator of drug use and a barrier to recovery in Chapters Three and Four) and improved wellbeing is a vital element of treatment and aftercare (Best et al., 2016), the opportunity to engage in frank discussion with other service users with whom they can relate seems a central facet the recovery journey for those with co-occurring disorders (c).

Group-based treatment interventions are not without limitations, however. One such limitation is the didactic approach that some interventions employ. A didactic approach to group treatment (wherein a class takes the form of a lecture, rather than a discussion) has generally been shown to be an ineffective method in substance use treatment. Instead, group interventions are best served when they incorporate interpersonal group relations into treatment (Wendt and Gone, 2018), such as Alcoholics Anonymous or Personal Development. Indeed, the current study supported this conclusion, as Katherine noted:

> "In other classes [besides Personal Development], I've been there, and I'm just like, 'oh my fucking God, I'm back in school. I'm the dull one in class."

It is notable that Katherine refers to this particular intervention as 'class' as it further emphasises her school analogy, and suggests that didactic approaches to group-treatment interventions may negatively affect self-esteem ("I'm the dull one in class"), and may therefore be less engaging. This suggests that group interventions should attempt to be as interactive as possible, to avoid alienating those who did not engage well during school with this type of learning. This sentiment was also highlighted in Pallaveshi and colleagues' (2014) study, as one participant explained whilst discussing her dislike of the rigid structure of one group-treatment: "it seems like school, and I hated school" (p. 392).

Participants of the current study valued the interpersonal aspect of group treatment, and the sharing of experiences that accompanied it. As Vaughn discussed whilst discussing his appreciation of listening to the lived experience of other members, as opposed to the group just reading from the Big Book during 12-step meetings:

> "The stories I've heard mate are fucking unreal but um, yeah. But then like I say you get a little snippet of their past, is what's happened to you. Somewhere along the line of when they're talking it's happened to you. I can guarantee it. But yeah, it seems to sink in more than if you are just reading out the Big Book [during a meeting], so you're left with just a page."

The above response seems to support the view that didactic forms of group-intervention are less popular, and less effective, than those which focus on group discussion of shared experience (Wendt and Gone, 2018). Vaughn highlights that information derived through group discussion of lived experience seems to "sink in more" than a didactic approach wherein the group just read out of the Big Book[52]. This suggests that interpersonal relations, and the social capital associated with this, is the central facet through which recovery groups are effective. This supports findings from a previous systematic review of AA which found that

[52] The 'Big Book' refers to the book written by the co-founder of Alcoholics Anonymous, Bill Wilson. The text details the 12-step method often used in the treatment of various substance use disorders, although originally intended for alcohol addiction

it may not necessarily be the content or practices of the group that facilitate and sustain recovery, but rather their ability to foster supportive networks, enhance motivation and develop self-efficacy and coping skills (Kelly, Magill, & Stout, 2009).

The negative impact of an aggressive, and confrontational tone found within certain 12-step based group-interventions was also raised by some service users. Owen stated that when you're vulnerable, "language is really important", and that aggressive language was quite common-place in 12-step based groups. He exemplified phrases such as "we break you down to build you back up again", and joked that "it's not the army, it's treatment". A military analogy was also used by Christopher whilst discussing why he did not complete Primary Treatment:

> Christopher: "I didn't actually complete the whole thing, I was, I was told that it was doing me more harm than good."
>
> Interviewer: "Can you explain that a little bit?"
>
> Christopher: "Well, my counsellor just said to me 'If you keep doing group, it's just going to cause you harm, and I don't want to cause you harm, so I think it's better if you come out of Primary Treatment now.' Because I'd hit a wall, I'd mentally hit a wall."
>
> Interviewer: "What do you mean by that?"
>
> Christopher: "Um, I just found it, quite aggressive. I'd be sitting there and I'd have five or six people firing questions at me, and by the time I'd try to deal with the first one, I was being told that… I'm not opening up and I'd be like 'well hang on *laughs*, there's six of you here and there's one of me. I'm trying to think about what that person told me', and then I said, 'it's like being put up against the wall and being shot with a machine gun' *laughs*. Um, it definitely helped. The information I found very malleable and all of the paper work I've still got in my file at home and I still used it to help me go through the Steps."

As Christopher states, he found Primary Treatment quite "aggressive" and used the analogy of being "put up against the wall" and "shot with a machine gun". The military terminology used by both Owen and Christopher to describe elements of group interventions based on the 12-steps indicates that they can be quite militant in their delivery, and that this is problematic for service users with co-occurring disorders (c). Moreover, this excerpt of

conversation suggests that confrontation during peer-group treatment can be overwhelming for service users with co-occurring disorders (c), and may create a barrier to treatment success. This is in line with previous research which has highlighted that group-interventions for those with co-occurring disorders (a) should be non-confrontational (Drake and Noordsy, 1994, cited in: Petersen and McBride, 2002; Marcel *et al*., 2016). As noted by Marcel and colleagues (2016), whilst psychosocial groups are a valuable treatment modality for those with co-occurring disorders (a), such groups must be non-confrontational, as emotional distress can exacerbate mental illness and will be damaging to those with co-occurring disorders (a). However, it should be noted that despite this, Christopher still found this group helpful, and alludes to the benefits of using booklets to reinforce treatment advice. This method allowed him to return to the work booklets after he had left the group to support him through the 12-steps. Christopher and Owen's remarks seem to provide some supporting evidence for Mueser, Drake, Sigmon and Brunette (2008), who found that those with co-occurring disorders (a) were better served through CBT-based group interventions than standard 12-step approaches.

In addition to the above criticisms, some service users found the 12-step approach to be overtly negative, and impeded their ability to progress past their problems with substance use. Indeed, this critique has been highlighted by previous authors who highlighted that the disease model philosophy that underpins AA may prevent service users from putting their substance use problems behind them (Tirbutt and Tirbutt, 2009). In contrast to the hopefulness purported by service users in this study, some service users I spoke with during participant observation found the service "miserable" and were reluctant to engage with it. Nathan also felt that AA was too negative, and this dissuaded him from engaging with it. Whilst discussing some conversations he had had during AA meetings, he stated:

> "[She was saying] 'As long as we can get through the day now and get my head on the pillow without downing a drink.' I was like, '*Fucking hell* [emphasis of participant], I can't live my life like that, minute-by-minute.' But then you know, some people have said, 'Well you're it [an alcoholic], heartbeat-by-heartbeat.' Yeah but you've got to make some kind of plans, or have *some* [emphasis of participant] kind of vision for the future. You can't just have *now* [emphasis of participant]. I was like 'When was the last time you had a drink?' and the person was like '15 years ago...' and I'm like 'I do *not* [emphasis of participant] want to be like that in 15 years' time.'" … "I'm instantly,

> inside my mind, just thinking 'I can't fucking… I can't even come to these sessions anymore.' I thought, because I can't hear that. That's *negative as fuck* [emphasis of participant]."

Nathan feels like 12-steps groups promote a "minute-by-minute" existence, and emphasises the importance of having a "vision for the future", suggesting that he feels 12-steps groups may impede this. Moreover, the interaction Nathan details in his response suggests that the internalisation of the 'alcoholic' label required to progress in 12-step treatment may inhibit personal development as the label becomes a defining attribute of the individual. Nathan states that this mind-set is "*negative as fuck*", and such accounts resulted in him disengaging with the group. Along with highlighting the importance of promoting hopefulness in treatment for those with co-occurring disorders (c), the excerpt also supports the critique mentioned above that the disease model of addiction may prevent service users from moving past their previous problems with substance use (Tirbutt and Tirbutt, 2009).

Owen further articulated this point, and said that 12-step approaches can become "part of people's lives, forever" and explains that there are still people engaged with 12-step who have, "Seen me go from where I was, to where I am now, and they're still coming back and still saying the same stuff they said 8 years ago." He went on to state the following:

> "If I could adopt this badge of 'addict' or 'alcoholic' or whatever, I would find it really difficult to keep taking responsibility for what I've done because I would be saying 'well you know, look, I am an addict, you know. You put your hand in the alligator's mouth and you're going to get bit.' You know, I'd start talking like that and… using it as my little 'Get Out of Jail Free Card'. It's the opposite of empowering, you know."

Owen articulated that the assimilation of an "addict" or "alcoholic" label is "the opposite of empowering", as it removes personal responsibility, something which has been highlighted as central to the recovery process of mental illness (Slade, 2010). This suggests that the absolution of responsibility through the internalisation of such a label, which has been central to the destigmatising aspect of 12-step recovery, may also present as a barrier to treatment for some service users with co-occurring disorders (c). The internalisation of a negative label can define an individuals' sense of self (Becker, 1991; Maruna, Lebel, Mitchell and Naples, 2004), and be used to rationalise behaviour and inhibit change (Petersen and McBride, 2002).

As Owen suggests, this presents a challenge for 12-step programmes as the approach requires an individual to admit they are an addict/alcoholic who is powerless over a substance, and mandate that this label be internalised in order to progress through the steps. This is problematic, as it has been recognised that an aggressive confrontation over the acceptance of such a label can be detrimental to treatment success (Petersen and McBride, 2002). Owen indicates that whilst he believes it is important to accept responsibility for past mistakes, he does not want to be defined by them. This suggests that perhaps by maintaining a grasp over their past missteps, individuals are able to demonstrate the personal development and progress that they have made.

The empowerment of service users and the promotion of personal responsibility have been described as crucial facilitators of the recovery process for mental illness (Slade, 2010) and co-occurring disorders (a) (Sacks, Ries and Ziedonis, 2005). Yet, Owen's response suggests that the disease model philosophy that underpins 12-step approaches may impede this, as the adoption of the addict/alcoholic label is disempowering. This conclusion was articulated by Marlatt (2002), who discussed that the disease model philosophy absolves the service users of personal responsibility through its requirement of personal "helplessness" over their problem substance, and the dependence on a Higher Power for salvation. In this sense, it may be important to change the language of 12-step approaches. Replacing "I am an addict" with "I have an addiction" may result in the progression from a controlling perspective, toward an emergent, empowering and progressive one (Dupuy, 2008), wherein substance use is a problem which can be overcome, and not one which someone is always beholden to.

Zinman (1998) argued that the identity which service users forge as a result of the labels imposed onto them help facilitate an 'us and them' attitude, wherein a belief is perpetuated that only those with mutual experience can understand them (cited in: Mead, Hilton and Curtis, 2001). This is perhaps the rationale behind the appreciation of peer-led support, but also suggests that labelling may also promote identities which damage an individual's ability to out-grow it.

"It holds up a mirror, in a really good way": The Role of Peer Mentoring in Recovery

Peers and peer mentors are those whom a service user can relate to through shared experience, who can offer support, advice and inspiration to aid recovery from substance use and mental health problems. The line between the two is blurred and engagement with either offer similar benefits (i.e. motivation, hope, advice). However, a peer mentor is often a more formalised version of peer-support, someone who a service user can look up to, who can provide support and guidance based on their personal experience (Truong, Gallo, Roter and Joo, in press). Peer mentors are those who are seen to have battled their problems with substance use and/or mental illness and 'come out of the other side', inspired to help others address the problems they suffered with. They are those who have progressed further along the journey to recovery, often through engaging with and completing a treatment programme. The relatability afforded to them through their own experience places them in a unique position to address the disconnection many service users feel when speaking with staff who do not have personal experience of mental illness or substance use problems. This subsection will discuss the role of peer mentors in the recovery process, and the implications this approach has for both the mentor and mentee.

As suggested above, empowering service users with co-occurring disorders (c) through interaction with peers is an important part of recovery and is therefore beneficial for treatment services to promote. Peer mentoring perhaps represents a further example of this empowerment. Peer mentoring is a prominent example of peer-led support within the substance-use field, and many of those employed at WCADA have had their own experience with anxiety and depression, or are ex-service users themselves. Their personal experience provides them unique insight into the problems faced by service users, and as such they are often able to provide valuable advice, and share coping strategies based on their lived experience (Maguire, Holloway and Bennett, 2014; Murthy *et al*., 2016; Truong *et al*., in press). However, it is important to note that there is no singular or linear process of recovery. It is a varied and dynamic process and not all service users sustain recovery through becoming a peer mentor.

While the term 'peer mentor' is often used to describe ex-service users' who have entered employment within the substance use field and manage a caseload (Maguire *et al*., 2014), the role is similar to that of a sponsor within 12-step groups. That is, an individual who has progressed further along the recovery process who is able to offer support and guidance based on their own experience to those who have more recently entered treatment or began their recovery journey. For the purpose of this section, the term 'peer mentor' will refer to those who service users considered to be further along the recovery path, who have had broadly similar experiences to their own, and can relate to through shared lived-experience. As such, a peer mentor is not only someone with the job title of 'peer mentor', but also sponsors, other staff members, and in one case articulated below, a church pastor.

Similar to peer-group interventions, the relatability of staff[53] was deemed important by service users. Previous research has indicated that service users place less value on the advice of someone who has "read it from a book" compared to advice from someone whom they are able to relate through personal experience (Maguire *et al*., 2014: 68). In this sense, advice resonates further when it comes from someone with similar lived experience. Relatability also reminds service users that they are not alone in their problems, as Owen mentioned:

> "[being a peer mentor] offers that little bit of relatability as well too. You know, because once you have a rapport with someone, sometimes just hearing their accounts of this makes you realise that 'Oh I'm not some sort of isolated freak. This [anxiety and depression] is actually kind of universal.' That helps."

As discussed in previous chapters, feelings of isolation are problematic for the recovery process. Owen suggests that relatability with staff helps to alleviate these feelings of isolation and, therefore, may be an important factor for treatment services to consider when assisting those with co-occurring disorders (c). Similar to the quote provided previously by Vaughn

[53] I have used the term staff to refer to those employed by WCADA in this study, and it refers to both peer mentors and those without specific experience of substance use and mental disorders. However, although the label of staff is provided to those employed by treatment services, becoming a peer-mentor is a central element of developing a new sense of identity and purpose for many service users (something that is discussed in greater depth later in the chapter). Therefore, peer-mentors never relinquish this identity when becoming a staff member, instead it becomes an integral part of their new-formed sense of self as a 'wounded healer'.

regarding substance use problems ("it's nice to know I'm not the only one"), Owen suggests that hearing accounts from other people with similar lived experience of reminds you that you are "not some sort of isolated freak" and, in fact, these problems are quite common place. This lends support to research from Mead, Hilton and Curtis (2001) who highlighted that hearing the experiences of other peers in recovery helps promote a feeling of relief that you are not isolated in your experience, and that others have articulated similar concerns. This suggests that peer mentors who have their own experience with mental illness may be an important mechanism to reduce the stigma around mental illness through making service users feel less alone in their experiences.

Those with co-occurring disorders (c) may feel averse to staff whom they feel do not understand their mental health issues, as they have not experienced it for themselves:

> "I said to [staff member name], 'You don't have mental health issues though, *that's the thing* [emphasis of participant].' I said, 'You were just a smack head!'" … "because there's a big difference between drug abuse and actually having mental health issues *and* [emphasis of participant] having them both together. There's a big difference.'"

Nathan highlights that those with co-occurring disorders (c) may be reluctant to accept the advice and support of staff who they feel cannot relate to their problems through personal experience, suggesting a lack of personal experience may damage the therapeutic alliance[54] between service users and staff. Whilst discussing his anxiety and the panic attacks he experiences, Nathan stated that: "You either know, or you don't, unfortunately. There's no in the middle" and went on to explain: "if you've never actually suffered from it, you will *never actually know* [emphasis of participant]". Nathan seems to exhibit the 'us and them' attitude described by Zinman (1998) (cited in: Mead, *et al*., 2001), suggesting that those with co-occurring disorders (c) may appreciate the support of a mentor who has had their own experience with anxiety, who they can relate through personal experience. This supports a quote given by a service user during a recent longitudinal study into peer mentoring in Wales (Maguire *et al*., 2014: 68):

[54] The 'therapeutic alliance' is used to describe the relationship between professions (i.e. counsellors/peer mentors) and the service user

> "I prefer somebody who has walked that road, rather than somebody who has read it from a book. You know somebody who has actually done that walk, because they will know where I am coming from."

Notably, the participant also used the analogy of 'the road' to describe the recovery process, supporting the excerpt from Katherine earlier in the chapter. Sacks, Ries and Ziedonis (2005) state that counsellors in substance use treatment should improve their understanding of the signs and symptoms associated with mental health and mental illness. Therefore, staff who have experienced such mental health problems for themselves will be at a distinct advantage in this respect.

A peer mentor himself, Owen challenged the sentiment put forward Nathan:

> "A common thing, I always challenge it when I hear it, but a common thing that pretty much all of your client base says is 'I don't want to talk to someone who has just learnt through a book. I want someone who has just been through it, you know all my experiences.' And I always challenge it and I say 'I've never been through *your* [emphasis of participant] experiences. No one has. And someone who has learnt from a book, like is uh, just as… they know what anxiety feels like. They know what loss feels like. What sadness feels like. Um, they're still a human being. They're not some sort of weird, emotionless cyborg just because they learnt from a book'. I've learnt from books, it doesn't make me any less equipped you know. So yeah, but that's I think the general consensus of the client base is, they want someone who's quote: 'been through what they have been through'.**"**

Whilst acknowledging that service users desire the support of someone who has had similar lived experience, Owen highlights that just because someone has "learnt from a book" does not mean they are unequipped to deal with mental health and other related problems. However, this may only relate to common mental health problems, which are often exacerbated manifestations of normal human emotions. In regards to more serious forms of mental illness, this line of argument is more difficult to uphold. For example, just because someone understands sadness doesn't mean that they understand depression and, as Nathan suggests (p. 147), service users who suffer from mental illnesses may feel misunderstood by staff without personal experience of their mental disorder.

Both substance misuse and mental illness are topics associated with significant vulnerability; consequently, discussing such topics can be painful and leave service users feeling exposed. Therefore, staff appearing vulnerable to service users about their own experiences may make it easier for them to discuss their own vulnerabilities. As Denzin (1989: 43) states: "to listen only creates distrust". A willingness for self-disclosure therefore, seems a valuable characteristic in all staff, and indeed is a skill taught on many counselling courses. This sentiment was highlighted by Katherine during our interview:

> Katherine: "He tells you about himself as well. He doesn't just, he's not just there as a teacher, 'I can't tell you anything about me' type of thing. It's nice, it's relaxed, and as I said it's welcoming."
>
> Interviewer: "Why do you value [Peer Mentor's name] discussing his own experiences?"
>
> Katherine: "Because you don't feel judged as much."

In the excerpt above, Katherine explains that she values a peer mentor who is willing to discuss their own vulnerabilities and experiences (Truong *et al*., in press), and suggests that this openness is important reducing feelings of stigma and making service users feel more comfortable and welcomed during treatment (Audet and Everall, 2010). Truong and colleagues (ibid) suggested that self-disclosure from a peer mentor also helped strengthen the therapeutic alliance between service user and mentor, which has been highlighted as a crucial aspect of treatment for those with co-occurring disorders (a) (Alverson, Alverson, Drake, 2001; Sacks, Ries and Ziedonis, 2005; NICE, 2016; Christie, 2017; Strang *et al*., 2017). However, care should be taken that attempts at self-disclosure are appropriate and relevant, as it can blur the boundaries between formal support and friendship, and can have a damaging impact if given inappropriately (Audet and Everall, 2010).

A peer mentor is also an important source of hope for service users (Davidson, Bellamy, Guy and Miller, 2013). As Keith noted:

> "I've got the good support, because my pastor, he used to be into drugs himself. He was uh, had problems with cannabis and cocaine and he was a bevvy head [an alcoholic]. Same as what I was like, you know what I mean. And he's only two years

> older than me, so we can relate to each other like. So, he knows, he can look back and probably see his old self in me, and I can see my future in him. He's got it together like you know."

Keith's faith was very important to him and as such, his pastor became a valuable source of support in his recovery. As his pastor had personal experience with problematic substance use, Keith felt he could relate to him. His pastor was someone he could aspire to, someone who had overcome their problems with drugs and rebuilt their life. Keith's response echoes the sentiments highlighted by service users in a recent longitudinal evaluation of a peer mentoring programme in Wales. The authors found that service users valued the support and guidance of someone who they could relate to through shared experience and that these relationships promoted a sense of hopefulness, that someone in their position had overcome their problems to rebuild their life (Maguire *et al*., 2014).

Discussions with Peer Mentors throughout participant observation and during interviews also highlighted that peer mentoring has a positive effect on the peer mentor themselves (Maguire *et al*., 2014; Dugdale, Elison, Davies, Ward and Dalton, 2016). When asked to sum-up his feelings about his work as a peer mentor in a few words, Owen stated: "empowering and motivating". He went on to say:

> "I think um, there's a lot to be said about peer-led support. I think uh, peer-led support is one of the most important things in any recovery. Um, because seeing people in a similar position to you um, kind of holds up a mirror, in a really good way. Uh, and also brings out an empathic part in you of wanting to help someone as well." … "it kind of spurs you on to be okay so that you can help other people."

Owen believes that peer-led support is a vital aspect in any recovery, not just for those with co-occurring disorders (c), because it "holds up a mirror, in a really good way". This suggests that the similar lived experience shared by service users and peer mentors may offer service users a sense of encouragement and hope, as peer mentors demonstrate that it is possible to overcome the problems service users are facing. Moreover, Owen states that helping other people through his work as a peer mentor solidified his own recovery, a finding that also been demonstrated in previous studies (Maguire *et al*., 2014; Dugdale *et al*., 2016). Moreover,

Owen's drive to help others lends support to the 'wounded healer' theory, which will be discussed in more depth later in the chapter.

Peer mentoring within substance use treatment also has some drawbacks. Namely, tribalism in regard to treatment approach. That is, that peer mentors may push a service user toward a certain treatment approach because it worked for them, even if this approach is not appropriate for the individual concerned (Sacks, Ries and Ziedonis, 2005):

> "We work to our skills and we use what has worked for us ultimately and thus, the sort of um, those are the arrows in the quiver that we reach for."

This excerpt from Owen's interview highlights that for many peer mentors, this is a perfectly logical thing to do. As Owen notes, peer mentors use their personal experience to guide and support service users through the treatment process and, as such, they draw upon the skill-set they have acquired. However, as noted by Sacks, Ries and Ziedonis (2005), no treatment is universally effective and applicable for those with co-occurring disorders (a). Instead, treatment plans should be developed in collaboration with the service user, with regard to their individual context (Strang *et al*., 2017). Therefore, peer mentors should be encouraged to broaden their horizon of treatment approaches, and recognise that they are not universally effective and that recovery is an individualised process. As Owen explained, trying to force a service user toward a method of treatment simply because it worked for you will be detrimental to their recovery:

> "If you have one rigid approach that you believe works… I think that is a massive setback in therapeutic benefits of your service."

"Helping people just makes you feel good, doesn't it?": A Pathway to Employment

Peer mentoring seems a useful role for both the mentor and the mentee (Maguire, Holloway, and Bennett, 2014). This section will consider how many service users feel they are 'not ready' for employment and find the prospect of securing a job daunting. Indeed, they are advised to put their recovery first and not rush back into a job. However, almost every service user spoke

of the desire to "give something back" and help others in similar vulnerable situations, supporting the 'wounded healers' hypothesis (Maruna, LeBel, Mitchell, and Naples, 2004; Kirkcaldy, 2013). This section will propose that, as many service users desire to help others, peer mentoring may provide an effective method of both gaining employment and facilitating the recovery process. In addition, this section will explore the potential role that altruistic[55] endeavours such as volunteering may have as a stepping-stone toward paid employment.

Recovery Comes First

Commonplace among those with co-occurring disorders (a), unemployment is associated with suicide (Wyllie *et al*., 2012), as well as increased levels of anxiety and depression (Marmot *et al*., 2010; Ishmuhametov and Palma, 2017). However, despite the difficulty in attaining employment, previous research has suggested that finding a job can encourage a sense of achievement (Ishmuhametov and Palma, 2017) and help build confidence and social competency (Best *et al*., 2013; Maguire *et al*., 2014; Cano *et al*., 2017), which are key for good mental health, and vital in order to reintroduce oneself back into societal living (Vangeest and Jonson, 2005; Best *et al*., 2013; 2015).

Many service users are cautious about returning to work and indeed, are advised against it during treatment. Whilst discussing the prospect of employment, Christopher explained why he was cautious about rushing into it:

> "If I went back into work now, it would become… I'm worried that my recovery would take a step back. I wouldn't be going to meetings, I wouldn't socialise with the same people I am now, I wouldn't have that… I would say strength around me, which is keeping me… keeping me doing what I'm doing basically. I worry that if I start work, I wouldn't have the time to, to go through the steps, I'd lose touch with my sponsor or my mates, it's just… I've seen it happen to people before."

Christopher states that he is anxious that his "recovery would take a step back" if he went back to work at the moment, and that he "wouldn't have time" to put the necessary focus on

[55] Although the term altruism implies total selflessness, this is perhaps unrealistic as we always gain something from our involvement in an altruistic act (even if this is just the sense of happiness we feel by doing it). Volunteering therefore, may still be seen as an altruistic pursuit given its focus on helping others, even though we may help ourselves in the process.

his recovery. Notably, supporting evidence from the current and previous chapter, Christopher emphasises the importance of peer-support in his recovery and the "strength" this provides him, further supporting the important role social capital has in the recovery process (Cloud and Granfield, 2009; Best and Laudet, 2010; Hennessy, 2017). Christopher went on to explain that the pressures involved with employment would mean he would lose focus on his own personal development:

> "[If I start work] my main priority becomes 'Oh my job comes first' whereas actually, I need to put myself first because if I don't look after myself, how can I do my job? *laughs*."

Christopher's humour highlights an important point: unless service users are able to put the required time into their own personal development, any future efforts in employment will suffer. As he stated in his previous quote, he's "seen it happen to people before" (suggesting this occurrence may be common place) and, therefore, he is unwilling to take the risk of potentially hindering his recovery by getting a job until he is sure of his own recovery. This relates to evidence provided in Chapter Four, which highlighted the differing perspectives from the DWP and treatment services regarding employment and the barrier this may present to recovery – if a service user is pushed toward employment before they are ready, it is likely to negatively affect their recovery prospects.

Morgan also mentioned that he had been careful not to rush back into employment after he became aware that his recovery was still fragile:

> "I, I was ready to go off and start work sort of last year and I had a bit of a sort of… I had a, again I didn't really relapse, but, um… a couple of things happened around sort of Christmas that made me think: 'Actually you know, you're still very raw with this and if you do go out and things don't go your way… there is a chance that you know, you could go back to it'. And I'd just, I don't want to, I really don't want to this time round so you know, so I will do what's necessary you know"

Morgan's response seems to indicate the fear articulated by Christopher. Morgan suggests that some distressing events left him realising that there was a chance he could relapse if he wasn't not careful and he decided not to rush back into work as a result. This implies that Morgan is worried that the stress associated with employment may cause him to relapse. This

supports evidence from previous chapters that highlighted stress as facilitator of drug use and a barrier to recovery, and indicates the importance of robust aftercare programmes to support service users into employment.

Morgan and Christopher's responses were also echoed by Edward during a discussion about employment during the interview:

> Edward: I don't think I'm quite ready for it [a job] now."
>
> Interviewer: "Is there… how come? Is there a reason?"
>
> Edward: "I'm not quite stable enough, you know… emotionally, or mentally, whichever way you want to look at it. Um, I'm not quite sort of, on track enough for that yet."

Edward explains that his mental health presents as a barrier to his employment prospects (Neale and Kemp, 2009), as he feels he is not "stable enough" for a job. He went on to explain that:

> "[In treatment] there's a general feeling that people shouldn't rush into things like employment. Especially full-time employment, if they aren't feeling ready for it. Especially if they've got a history of alcohol or drug misuse and they might, or perhaps have mental health problems on top of that. You know, uh, don't try to run before you can walk kind of thing."

Reiterating the sentiment highlighted by Morgan and Christopher, Edward explains that those with substance use and mental health problems should not "try to run before [they] can walk" in regards to seeking employment; suggesting service users should focus on stabilising and improving their mental health before returning to work. However, his specificity toward full-time employment also suggests that perhaps a low-pressure, less time-intensive employment opportunity, such as volunteering, may present as a viable alternative, and ease service users into paid employment. Moreover, the interview excerpts provided above (wherein service users describe not feeling ready for work) may relate to a previous comment made by Morgan in which he compares treatment itself to "a bit of a job". This suggests that the time and effort required for recovery is not reconcilable with employment.

Despite several participants articulating that they felt they were not ready to get back into employment, the majority did want to return to work and spoke about their desire to focus their attention on helping others. This will be the topic of the final subsection below.

Wounded Healers

Tirbutt and Tirbutt (2009: 54) stated that "Those who have managed to conquer drink problems have an exceptional faculty for getting through to, and helping, others who still have drink problems". Although the above quotation only refers to drink problems, the premise that those who have been through a recovery process and have 'come out of the other side' are well-suited to help those in similar situations is well documented. The process of 'the wounded healer' has been highlighted in the rehabilitation of offenders (LeBel, Richie and Maruna, 2014), and in the treatment of those with mental disorders and substance use problems (Telepak, 2010; White, 2000).

Service users in substance use treatment often experience feelings of guilt and shame, and such feelings can have negative consequences for the recovery process (McGaffin, Lyons and Deane, 2013). Becoming a 'wounded healer' may help service users address these feelings, and help sustain recovery by converting past-experience from a source of shame or guilt, into a valuable source of wisdom and insight to help others who find themselves in similar situations to where they once were (LeBel, Richie and Maruna, 2014). Moreover, as stigma has been highlighted as a barrier to recovery, this process can "allow for stigmatised individuals to overcome their labels and reconcile with society" (LeBel, Richie and Maruna, 2014: 110).

Although almost all service users expressed not feeling ready to return to work, every service user described that once they were ready, they wanted to "give something back". Nathan expressed that he'd "always taken from society" and nowadays he tries to "fill [his] karma bucket up more". Nathan went on to discuss that he is considering volunteering at WCADA as method of achieving this goal:

> "I know one boy who works, he's got a job here now. And he was just volunteering, and I was thinking, 'well you know, that, I could give something back like you know?' and get into that. Maybe volunteer for a while."

Nathan's response suggests that service users may seek volunteer work as a method of "'earned redemption'" (Bazemore, 1998:768, cited in: Maruna, *et al*. 2004: 279), as it provides them with an opportunity to redress their past behaviour. Moreover, Nathan suggests that seeing another service user progress from client to volunteer to employee, had spurred him on to follow a similar path. A perceived lack of opportunity for the future can develop a sense of hopelessness (Maruna, *et al*., 2004), and therefore this highlights that the service user-volunteer-employee pathway is a valuable source of hope for service users. Owen expressed a similar sentiment:

> "I was seeing people who, uh… I'd met and joked and got to know as clients, suddenly become workers. And, really competent ones at that. And… that voice in my head that told me I couldn't do anything, it was getting really, really hard to find evidence to back that voice up because I was doing things, and they were helping me do things, and I could see that… this goal that was ridiculous, of becoming employed… wasn't that ridiculous anymore. It was actually really achievable. Um, so… yeah that was super important in recovery were those other people and seeing them do well."

As Owen states, seeing those who he had socialised with during treatment become "really competent" workers helped improve his self-confidence, and provided him with a sense of hopefulness that his "ridiculous" goal of becoming employed "wasn't that ridiculous anymore". This suggests that a volunteer-employment scheme (a common pathway for Peer Mentors) may improve recovery prospects for those with co-occurring disorders (c) by improving self-confidence and challenging the negative thought process associated with anxiety and depression, (i.e. "that voice in my head that told me I couldn't do anything, it was getting really, really hard to find evidence to back that voice up"). Owen's response also resonates significantly with previous research from Best and Laudet (2010) who highlighted that recovery prospects are enhanced when those around the service users are also achieving success in their own recovery journey, and suggests that one mechanism through which this occurs is through a reduction in self-deprecating thought processes, and by developing a sense of hopefulness.

Volunteering may offer a low-pressure opportunity to gain valuable employment experience and improve mental wellbeing. Despite his belief that service users should not rush back into employment, Christopher believed that WCADA should "get more people involved with volunteering". His distinction between employment and volunteer work is perhaps that volunteer work is a less pressurised environment, but also that volunteer work is more meaningful and therefore more rewarding:

> "Helping people just makes you feel good, doesn't it? Because when you come into recovery you're full of self-pity and depression and… I, I do see people… fearful as well, but when you've, when you've gone through treatment, it gives you that confidence and self-respect and self-worth back and then you want to go out and you want to help people get a similar thing"

Christopher suggests that treatment improved his confidence and self-worth, and this spurred him on to help other people in his situation achieve the same thing, which improved his wellbeing (Ryff, 1989). This indicates that helping others may be an important facilitator in the treatment of co-occurring disorders (c). Maruna and colleagues (2004) highlighted that ex-prisoners often developed a sense of purpose, self-worth and satisfaction through altruism, and finding a meaningful cause in which to invest their time. This is significant as purpose and meaning are key aspects of wellbeing (Ryff, 1989) and poor wellbeing often precipitates substance misuse (Graham and Schmidt, 1999; Veenhoven, 2008; Mentzakis, Suhrcke, Roberts, Murphy and McKee, 2013) and is negatively associated with mental illness (Binder and Coad, 2013). Strang and colleagues (2017) highlighted that one of the significant benefits of mutual aid groups is the positive effects associated with altruistic behaviour. As Christopher suggests, volunteer work may present a valuable opportunity to achieve this. Christopher's response also seems to resonate with the generativity concept[56], which suggests that Christopher's desire to help others may represent a desire to redeem himself from past mistakes (Maruna, 2001: McNeill and Maruna, 2007).

[56] The generativity concept is a theory used within the psychology/criminology field, which refers to the often-encountered desire among individuals with anti-social or traumatic pasts to help others through similar situations to those which they have experienced (for example, peer mentors in substance use treatment). They often express the drive to redeem themselves for perceived past wrongdoing and leave some kind of positive legacy.

Katherine also stated that she "*definitely* [emphasis of participant]" wanted to help other service users who were in the same position as she was when asked what she wanted from her future:

> "I'd like to be seeing my children. Have my house the way that I want it… as in decorated and stuff like that… if I can, be volunteering somewhere, helping. You know? Helping other people you know where I was, and help them through... I *definitely* [emphasis of participant] wanna do that."

Along with other important milestones that she would like to achieve, Katherine highlights again the drive many service users feel toward helping other people. This suggests that meaningful work through helping others, either through peer mentoring or volunteer work with other service providers, may serve as a facilitator toward future employment.

A recent literature review based on studies between 1990 and 2010 highlighted that failing to secure employment post-treatment was significantly associated with relapse (Henkel, 2011; as cited in: McKay, 2017). Therefore, helping service users attain employment once they finish treatment (and are ready to do so) is essential. Although many service users are cautious about this prospect as they do not want to jeopardise their recovery, many expressed a willingness to volunteer and a strong desire to help others. This provides evidence for the generativity concept and the wounded healer theory and suggests that the volunteer-employment pathway offered by WCADA and other substance use services (Maguire, Holloway and Bennett, 2014) may serve as an important stepping-stone toward employment. Furthermore, substance use services may benefit from liaison with local charities to seek low-pressure opportunities for service users to volunteer in a sector they are passionate about, as engagement in work they find meaningful may improve their self-confidence, self-worth and provide them with a sense of "identity, belonging and purpose" that can help sustain recovery (Best *et al*., 2013: 277). Indeed, the National Institute for Health and Care Excellence suggests promoting volunteer opportunities with local services as an important facilitator of the recovery process for those with co-occurring disorders (a) (NICE, 2016). This could provide valuable experience for later employment in an area they are passionate about and help reduce the stigma surrounding those in substance use treatment through increased interaction with local communities. Moreover, giving service users small

parts of responsibility helps demonstrate trust and encourage self-change (Maruna *et al*., 2004: 278), which Owen emphasised as important:

> "Little bits of responsibilities trickling into my life uh, built my confidence up enough so I was realising that I was able to complete tasks, I was able to do stuff."

Transitioning into a role wherein service users are able to help others can also promote feelings of self-confidence, self-esteem, accomplishment and develop a sense of meaning and purpose (LeBel, Richie and Maruna, 2014), all of which are important factors in good mental health (WHO, 2005) and wellbeing (Ryff, 1989). Developing a sense of purpose is an important facilitator of the recovery process (Harris, Fallot and Berley, 2005; NICE, 2016; McKay, 2017), as years of substance use often leaves service users bereft of any meaning in their lives (Harris, Fallot and Berley, 2005). As Owen discussed, the lack of purpose he felt while he was using diminished his sense of self-value:

> Owen: "I felt purposeless when I was you know, before I was a client, in that period of my life. I was like, 'If [own name] disappeared off the face of the world, there would be no impact. There would be no difference.' Um… like, so that's, but then giving me a purpose kind of made me value myself a bit more, uh, cause I always had value, everyone has value, but to value yourself is an important thing and I think that comes from having a purpose."
>
> Interviewer: "What was it about your treatment that gave you that sense of purpose?"
>
> Owen: "The idea that maybe I would be able to… help someone else."

Owen describes that having no purpose in life made him feel insignificant, that if he "disappeared off the face of the world, there would be no impact". Similar to Christopher, Owen also highlights the generativity concept. His search for purpose and meaning, and fear that life is unimportant, may be driving him to leave a legacy of some kind, so that he would be remembered (McNeill and Maruna, 2007). In line with previous research (Drake, Wallach and McGovern, 2005; Harris, Fallot and Berley, 2005; Hari, 2018; NICE, 2016), Owen describes the importance of developing a sense of purpose, and credits this to his work helping others as a peer mentor:

> "Having that human connection with someone, and hopefully like, changing someone's day for the better, even for that brief period of time just, yeah… gave me that purpose."

Owen's response supports statements made by peer mentors in previous research (Dugdale *et al*., 2016), which highlighted that becoming a peer mentor provided service users with a sense of purpose in their lives. Owen suggests that the opportunity to help others, provided through peer mentoring, is what gave him that sense of purpose. This indicates that work revolving around helping others is an important facet of recovery for those with co-occurring disorders (c), again highlighting the generativity concept (McNeill and Maruna, 2007).

In summary, it would seem that although many service users do not feel 'ready' to enter employment, they are motivated by a desire to help others with whom they can relate to from their own experience, supporting the 'wounded healers' hypothesis. This could be capitalised upon by treatment services as a way of supporting service users back into employment, as evidence from the current study suggests that although service users are cautious not to rush into employment, they are willing to volunteer themselves. This may perhaps be that volunteering involves less pressure, but nevertheless indicates that service users do aspire to find employment and would value the opportunity to "give something back" and help others with similar experiences to their own. Therefore, altruistic work may be an important aspect to consider in the treatment of those with co-occurring disorders (c).

Conclusion

In conclusion, this chapter has suggested that a salient feature of recovery for those with co-occurring disorders (c) is peer-led support. Peer-group interventions offer service users a space in which they can discuss stigmatised topics without fear of judgement, and feel safe and comfortable in doing so. Moreover, these groups provide service users with a valuable source of advice and support from those who they can relate to through shared experience and therefore, are an important source of social and human capital. However, this study has also suggested that such groups should avoid a didactic approach and be as interactive as possible, with focus on group discussion of shared experience, to help facilitate engagement and cultivate the necessary human and social capital to sustain recovery. Further, this study

suggests that such groups should not be confrontational and instead should focus on promoting a sense of hopefulness, as confrontational approaches can be damaging to those with co-occurring disorders (c) and cause them to disengage. Additionally, service users also highlighted that the internalisation of the 'addict/alcoholic' label required for 12-step groups may inhibit the recovery process.

Peer mentors also offer a valuable resource to service users, and are made more accessible through their ability to relate through their own lived experience. They provide a valuable source of hope for other service users that someone in their position is able to put their problems behind them and rebuild their life. They are also a significant source of social and human capital, as they are able to offer guidance and practical advice based on shared lived experience. Furthermore, this study suggests that service users who become peer mentors are able to solidify their own recovery by developing a sense of purpose and meaning through helping others, both of which are central factors in wellbeing (Ryff, 1989). However, peer mentors are susceptible to tribalism of approach, which is a limitation.

Finally, peer mentoring (and perhaps altruistic work more generally), seems to be an important facilitator of the recovery process for those with co-occurring disorders (c). Such work can have a positive impact on self-confidence, self-worth, and many service users expressed aspirations to engage in volunteer work or become peer mentors themselves. Moreover, as peer mentors in this study suggest, this work can also provide a sense of purpose and help maintain one's own recovery.

Chapter Seven: Conclusion

The previous chapters have explored the relationship between anxiety, depression and substance misuse from the standpoint of service users and peer mentors. The chapters also examined the recovery experience of this group and their perspectives on the treatment they received.

This conclusion chapter will provide an overview of the aims and objectives set out in the introduction of this thesis, a synopsis of the conclusions drawn from the literature review and a summary of the methodological approach adopted. The chapter will then discuss the three key findings of this research: the intrinsic relationship between anxiety, depression and substance misuse, the invaluable role of peer support in recovery and the role which helping others may have in supporting recovery and providing a pathway toward future employment. Limitations of the current study and suggestions for future research are also provided.

The Research Aim

Over the last few decades, the prevalence of co-occurring disorders (a) has been realised and highlighted by researchers, policy makers and practitioners. Co-occurring disorders (a) are associated with a number of adverse outcomes within treatment, including increased rates of relapse, suicide, financial instability and housing problems. However, despite the prevalence of co-occurring disorders (a), the topic remains under-researched.

Whilst reviewing the literature, it became clear that the UK suffered from a dearth of research on the subject, as studies were predominantly American. Furthermore, studies on those with co-occurring disorders (a) lacked focus on specific disorders. As anxiety and depression were highlighted as the most common disorders to co-occur with substance use problems, these were chosen to give this research the required focus. To date, to the author's knowledge, there have been no qualitative studies conducted in the UK which aim to engage with service users and peer mentors with co-occurring disorders (c) to better understand their recovery process and perspectives on the treatment experience. This is important, as

involving those experiencing treatment in the research process helps to improve the design and delivery of services (NICE, 2016).

Given the frequency with which anxiety and depression co-occur with substance use problems, the specificity provided by this research will hopefully go some way to improve the treatment prospects of this group and improve our understanding of how and why these mental illnesses co-occur with substance use problems, so that we are better equipped to prevent such disorders coalescing in the first place (as cited in: Lai, Clearly, Sitharthan and Hunt, 2015).

The Research Question

The overarching research question for this project was:

How is recovery experienced and understood by those with co-occurring anxiety and depression?

To address this question, the following themes were explored using qualitative methodology:

1. What are service users' experience of the treatment process?
    - What factors do service users believe facilitated their drug use?
    - What barriers to recovery do service users' experience?
    - What do service users' value from treatment?
2. To provide a contextual basis for the data, a life history element was also incorporated

The Research Objectives

To engage with service users and peer mentors, using qualitative methodology, to explore:

- Factors which facilitate the onset of substance misuse problems
- The relationship between anxiety, depression and substance misuse
- How those with co-occurring disorders (c) experience the recovery process
- The perspectives of those with co-occurring disorders (c) regarding the treatment they receive for their mental illness and substance use problem

Chapter One: A Summary

The literature review of this thesis highlighted that co-occurring disorders (a) are associated with a number of harms to both society and the individual. While a number of disorders may co-occur with a substance misuse problem, the most prominent disorders are anxiety and depression, which have been the focus of this research. The epidemiology of co-occurring disorders (a) is complex and multi-faceted. However, there are two prominent, non-exclusive, pathways through which they develop. Pathway one describes a process through which both disorders develop in response to shared vulnerabilities. These vulnerabilities are primarily based on external factors and both mental illness and substance use problems develop in response to them. For example, stress was highlighted as a significant factor in the development, maintenance and relapse of substance use disorders and mental disorders. Similarly, poverty and adverse life experience were also associated with drug use, poor mental health and mental illness. Pathway two describes a process wherein a mental disorder acts as a risk factor in the development of a substance use problem. In an effort to relieve states of dysphoria associated with their mental disorder, individuals may develop substance use problems through prolonged exposure to drugs.

A number of studies from the US highlighted similar barriers to treatment for those with co-occurring disorders (a). Negative affect, feelings of isolation, peer-pressure and poor levels of wellbeing were consistently linked with relapse among service users in substance use treatment. In these cases, drug use was often an attempt at coping with negative emotional states, or wanting to 'fit in' socially. The literature review also identified that while there is no treatment that is universally effective, a number of treatment interventions that have shown promise in treating those with co-occurring disorders (a). These included CBT, Behavioural Activation, mindfulness-based interventions, wellbeing therapies, and perhaps most importantly, peer support (i.e. group work and peer mentoring). Additionally, treatment approaches based on the Recovery Capital model have been successful in sustaining recovery.

Chapter Two: A Summary

The current study adopted a qualitative methodological approach given the vulnerability of participants, the sensitivity of the research question and the desire to elicit a rich and textured data set. This approach helped build trusting relationships between myself and the participants and also provided a nuanced and contextualised account of a relatively under-researched topic.

The data collection methods used in the current study were participant observation and semi-structured, qualitative interviewing. Interview participants were sampled using a mixture of purposive and volunteer sampling. In addition to helping establish trusting relationships between the researcher and participants, these methods provided the flexibility necessary to grapple with the complexity of the research topic and unconsidered avenues to be explored. It also helped establish the necessary contextual basis for the data. Interviews were audio recorded and transcribed verbatim.

To analyse the data, the current study employed thematic analysis. This highlighted any similarities and differences between the interviewees and helped highlight a number of salient topics to discuss within the thesis. Data was then interpreted, and compared and contrasted with other participants and the existing evidence base found within the literature.

Using this methodology, this thesis identified three key conclusions: (1) An intrinsic and synergistic relationship between substance use problems, anxiety and depression; (2) the significant value of peer support within recovery and its efficacy in helping to sustain recovery; (3) the notable desire of service users to 'give something back' by help other people, particularly those with similar lived experience to their own. Each of these conclusions is discussed below, along with their implications for treatment services.

The Intrinsic and Synergistic Relationship between Substance Use, Anxiety and Depression

The literature review of this thesis indicated that although the relationship between mental illness and substance use is poorly understood, the co-occurrence of internalising disorders (i.e. anxiety and depression) and substance use should be considered the rule, rather than the exception (Lai *et al*., 2015). This prevalence is problematic, as co-occurring disorders (a) are associated with a number of adverse outcomes such as poor treatment outcomes, increased risk of hospitalisation, unemployment and suicide (Torrens *et al*., 2015; NICE, 2016; Christie, 2017; Strang *et al*., 2017).

The current research has highlighted a synergistic and cyclical relationship between anxiety, depression and substance misuse, suggesting they should be considered as a whole rather than separate entities. However, mental illness seemed to be the primary driving force behind the initiation, maintenance and relapse of substance use problems among those with co-occurring disorders (c). A number of facilitators of drug use[57] and barriers to recovery[58] were identified in chapters Three and Four, respectively, all of which broadly related their impact on exacerbating anxious and depressive symptoms. In the absence of more positive ways of coping with adversity (internal or external), participants described turning to drugs as a coping mechanism (Bradizza *et al*., 2018). Whether it was to manage feelings of stress, inadequacy, boredom or loneliness, to avoid problems they did not know how to deal with, or to cope with traumatic pasts or feeling stigmatised, substance use became the primary method of relief from the dysphoria associated with their anxiety and depression and the adversity it exacerbated. However, substance use often exacerbated mental illness in the long-term, so therefore, mental illness may be seen as both a cause and consequence of substance use problems.

[57] Managing anxious and depressive symptoms, augmenting self-esteem and dealing with the negative thoughts and feelings associated with past trauma. The chapter also identified a lack of access to psychological support through the NHS as a factor which exacerbated mental illness and as a result, maintained substance use

[58] Re-engaging with substance-associated social networks, loneliness and boredom, stigma and the consequences associated with surviving on benefits and negative interactions with the Department of Work and Pensions

While both pathways implicated in Chapter One in the development of co-occurring disorders (a) hold merit for those with co-occurring disorders (c), the current study found more evidence to support pathway two (a mental illness acting as a risk factor). Substance use was consistently reported by participants as a coping mechanism to manage their anxiety and depression. However, as articulated in the literature review, the two pathways do not seem to be mutually exclusive and instead overlap significantly. Service users often discussed responding to distressing situations with substance use when they had no other means of coping. For example, stress was associated with poverty and financial instability and acted as a risk factor in the facilitation and relapse of substance use problems due to its adverse effect on mental illness (Sinha, 2008; Alim *et al*., 2012; Garland *et al*., 2016).

The current study provides support to the first tenet of the self-medication theory, but it did not find evidence for the archetypes or specificity in drug choice that Khantzian (1985; 2003) claims. Instead, drug preference was generally related to ambient community trends (Dixon, 1999) or ease of access; although, participants did describe avoiding drugs which they felt exacerbated their mental illness (Dixon, 1999) and heightened negative thought processes. Therefore, the more general 'Alleviation of Dysphoria' theory (Laudet *et al*., 2004) seems best suited to understand the development of co-occurring disorders (c). Those who suffer from anxiety and depression are more prone to poor mood and dysphoric states and as a result, seem to be more likely to resort to drug use to manage these states in the absence of more appropriate coping mechanisms (Bradizza *et al*., 2018).

While previous research has focused on the association between substance use and emotional regulation (Khantzian, 1997; 2003; Bradizza and Stasiewicz, 2003; Laudet *et al*., 2004; Harris, Fallot and Berley, 2005), the current study suggests that the suppression of anxious and depressive thoughts is the primary rationale behind continued substance use (Bowen *et al*., 2007). Anxiety and depression seem to provoke substance use through their role in perpetuating negatively valenced thought processes, particularly toward the self. Participants often described their drug use as a response to negative thoughts, using the verb *'I thought'* as opposed to *'I felt'*, suggesting that the thought process is a critical component of continued substance use. For example, supporting Beck's (1979) assertion of the sequential but dynamic relationship between negative thoughts and negative emotional states, the

current study highlighted poor self-worth as a risk factor for substance use as this led to critical self-evaluation and feelings of inadequacy, which led some participants to attempt to "edit" themselves into a more desirable version through drug use.

Although participants articulated using drugs as a coping mechanism to manage their anxiety and depression, the relationship between mental illness and substance use seems to be synergistic, with each exacerbating the other. This resulted in a self-perpetuating cycle that became difficult to break until service users received support to develop and establish more positive coping mechanisms. This resonates significantly with previous research that has emphasised the importance of cultivating human capital in recovery (Cloud and Granfield, 2009; Neale, Nettleton and Pickering, 2014; Hennessy, 2017).

Implications for Treatment Services

Given the interwoven relationship between substance use and mental illness, simultaneous treatment seems not only preferable, but necessary (Sacks, Ries and Ziedonis, 2005; Welsh Government, 2015; Torrens *et al*., 2015; Murthy *et al*., 2016; NICE, 2016; Priester *et al*., 2016; Christie, 2017). Service users described a "battle between the two [substance use and mental illness] of them"[59] and highlighted that you cannot address one in isolation from the other. The disconnect between substance use and mental health treatment services therefore, is problematic for those with co-occurring disorders (c). Indeed, many discussed their frustration at being unable to secure psychological treatment through their GP and the inadequacy of an exclusively medicinal approach (anti-depressants) to mental health treatment. However, service users placed great significant value on the counselling services provided at WCADA and articulated their appreciation of integrated mental health treatment within substance use services. Given the current policy in Wales surrounds collaboration between mental health and substance use services, this may represent a barrier to recovery for those with co-occurring disorders (c). Further research is required to explore this point.

Building resilience would also seem another important factor to consider within substance use treatment given that substance use was regularly described as a response to

[59] Katherine (p. 89)

distressing events, such as the financial insecurity of having one's benefits revoked, or the re-emergence of traumatic memories or triggers. Developing resilience may help buffer against adversity and prevent the onset of, or return to, substance use (Alim *et al*., 2012). Placing focus on the development of wellbeing within treatment may be one method of achieving this, given that higher levels of wellbeing have been associated with improved resilience (Ryff and Keyes, 1995; The World Health Organisation, 2005; Alim *et al*., 2012) and fewer relapses (Hoeppner *et al*., 2019). The DOMINO Project was consistently highlighted during this research with improvements in mental health and reduction in anxious and depressive symptoms, as well as helping to support and sustain recovery. Therefore naturally-rewarding, communal, activity-based programmes such as DOMINO seem to be important to incorporate within substance use treatment. Such programmes not only help service users cultivate valuable social and human capital, but also make engaging with treatment an appealing prospect (McKay, 2017). The regularity of DOMINO activities helped add structure and routine to the daily lives of service users, which helped them fill the void of free time associated with ceasing drug use, address feelings of boredom and build a lifestyle that does not centre around drugs. The communal aspect of this program was also especially important in helping service users address the isolation and related boredom associated with entering treatment and distancing themselves from substance-associated social circles, as well as providing valuable peer support.

The role of the thought process in the initiation of and relapse to substance use was also consistently highlighted in this research. This suggests that treatment approaches that directly target the thought process may yield positive results. Interventions that either challenge the thought process directly such as CBT, or those that change an individual's relationship with their thought process and how they react to negative thoughts such as mindfulness-based interventions could help service users with co-occurring disorders (c) to challenge or distance themselves from the negative thoughts that often led to drug use.

Peer Support: An Invaluable Asset to Cultivate During Recovery

Peer support has long been held in high regard within substance use treatment and has been shown to sustain and support the recovery process (Davidson *et al*., 2013; Murthy *et al*., 2016; Best, De Alwis and Burdett, 2017; Strang *et al*., 2017). Its strength lies in the empathetic connection gleaned through shared experiences (Mead, Hilton and Curtis, 2001) and in the power of community (Day, 2003). Peer relationships help develop new social norms based around recovery and pro-social behaviour (Flores *et al*., 2005; Drake *et al*., 2007; Best *et al*., 2015; 2016a) and produce benefits in both physical and mental health (Collinson and Best, 2019), as well as helping service users build a new, positive sense of identity (Best *et al*., 2015; Collinson and Best, 2019). This process guides the individual along the path along which their internalised 'addict identity' is supplanted with a new, more positive identity, free of the socially stigmatised connotations associated with problematic substance use (Best *et al*., 2016a).

Participants in the current study emphasised that the supportive relationships which develop during treatment and within recovery groups play an integral role in the recovery process. Service users placed a great deal of value on interaction and engagement with those who they could relate to through shared experience as these relationships offered a source of hope, motivation and optimism for the future. Substance use and mental illness are both associated with significant vulnerability and discussing them can be painful, leaving service users feeling exposed. However, knowing those around them had similar experiences to their own made service users feel less alone and allowed them to talk openly and honestly without feeling anxious, ashamed or stigmatised about their experiences. Additionally, peers were a significant source of support and guidance, and advice seemed to resonate significantly more when a service user felt they could relate to the individual providing it. In this way, interaction with peers during recovery helped participants build vital human capital (Cloud and Granfield, 2009; Hennessy, 2017) by listening to the coping mechanisms that worked for others and adapting them to their own situation. Although, some participants also identified that they did not feel staff without lived experience of their mental illness "understood" them and this disconnection meant that advice often did not resonate.

The value of social capital and the importance of cultivating it was also a central theme of this research. The recovery-oriented social support networks that service users developed during treatment and throughout their recovery formed an integral part of the recovery process and were a valuable source for service users to cultivate the necessary social and human capital to sustain recovery (Cloud and Granfield, 2009; Best and Laudet; Best *et al*., 2015; Hennessy, 2017). These new social networks were important to replace those associated with drug use and address the isolation many service users felt when they began their recovery journey. This was especially important for those with co-occurring disorders (c) as isolation and loneliness were associated with an increased negative thought process that precipitated relapse. Additionally, as the absence of motivation and hope are central facets of depressive (Jacobson *et al*., 2001) and co-occurring disorders (a) (Mueser *et al*., 2003), cultivating social capital was critical to this group. Fortunately, engagement with peers in recovery, particularly those further along the recovery journey, was identified as a source of insight, guidance and optimism that the seemingly impossible is achievable.

Recovery groups such as AA, group therapy during treatment and communal activity programmes such as the DOMINO Project played a significant role in the cultivation of both human and social capital. Group work such as AA or Personal Development[60] offered a formalised and structured environment that encouraged discussions on topics relevant to the challenges faced by service users. The interactive nature of these groups meant that service users were able to engage with one another, share experiences, advice and coping strategies without worrying about being judged. The interactive element of these groups was paramount, listening to the experiences of other service users was consistently highlighted as the element which participants valued the most. Contrastingly, a number of service users described not engaging as well with didactic approaches to these sessions and noted that just reading from the Big Book did not resonate as well as listening to and engaging with other service users in the group. Additionally, the assimilation of the "addict/alcoholic" label, as well as the personal helplessness over substance use required to progress within 12-step

[60] Personal Development was a CBT-based group therapy session provided at WCADA by Cyfle Cymru that involved a 12-week rolling course on various topics associated with substance use and poor mental health, such as anxiety, self-esteem and dealing with relapse.

groups were identified as problematic and disempowering. Labels have been highlighted in previous research as powerful mechanisms that can be used to rationalise behaviour (Petersen and McBride, 2002) and define an individuals' sense of self (Becker, 1991; Maruna *et al*., 2004), suggesting that the absolution of personal responsibility that has been central to the destigmatising aspect of these groups may have negative consequences. This research highlighted the importance of positivity within these groups, and suggested that aggressive and confrontational approaches are discouraging for those with co-occurring disorders (c) and may cause them to disengage with treatment.

The value of the DOMINO Project in particular was consistently articulated by service users and peer mentors in this study. Increased funding for the service was the most common response to questions related to what changes participants would like to see within their treatment. DOMINO helped service users avoid isolation through offering the opportunity to engage in communal, time-tabled activities with peers. Along with encouraging the development of social networks that are supportive of recovery and the social and human capital that go along with this, the regularity of the activities helped service users incorporate a sense of structure and routine to their lives in the absence of employment, which helped replace old routines associated with drug use. This was important, as isolation and a lack structure were associated with exacerbated negative thought processes that were conducive to relapse. Additionally, as relinquishing substance use was associated with a substantial increase in time that would have otherwise been spent engaging in substance-associated activities (Mercer and Woody, 1999), DOMINO offered a positively-reinforcing method of occupying this time, whilst helping to alleviate feelings of boredom that were linked with relapse. The focus on wellbeing within this service was also important (Hoeppner *et al*., 2019) given the lack of naturally rewarding stimuli associated with depression and substance use (Jacobson *et al*., 2001; Sacks, Ries and Ziedonis, 2005; McKay, 2017; Martinez-Vispo *et al*., 2018). Participants who engaged with DOMINO articulated the positive impact it had on their mental health and the important role the service had played in their recovery, something that was particularly mediated through the communal aspect of the service and the socialisation encouraged by it. DOMINO also helped improve treatment retention and offered a service that made recovery an appealing process to engage with.

Implications for Treatment Services

Given the significant value placed on peer support within recovery, it would seem that the development of recovery-oriented social support networks should be encouraged within the treatment setting. Socialisation with peers in recovery is an important source of hope, motivation, guidance and support for service users and is central in cultivating the social and human capital necessary to sustain recovery. DOMINO was the principle method through which these new social networks developed in this research, as it offered an informal and engaging environment for service users to socialise with each other. Therefore, communal, activity-based programmes that offer naturally rewarding experiences may be an effective tool in helping service users with co-occurring disorders (c) sustain their recovery through encouraging the development of social networks supportive of recovery. However, in contrast to other service users, one participant[61] mentioned that she did not want to make too many friends in treatment as she felt it would stop her moving on after treatment had concluded. Although this may have been because she was in a relationship and less susceptible to feeling isolated, it did raise an interesting question that future research would benefit from exploring: do the relationships that develop in treatment prevent service users from progressing beyond the treatment sphere?

Group work and peer mentoring were also highlighted as effective approaches for many of the same reasons discussed above. The social capital associated with these approaches was a valuable source of insight, motivation and hope for the future. The relatability service users' felt toward peer mentors and other peers also made discussing stigmatised topics less painful, as they could express themselves without fear of judgement. However, this research did highlight limitations associated with these approaches. The success of group work was centred upon the interpersonal relationships between members, and the sharing of experiences and coping strategies. Didactic approaches were not as effective. Participants also highlighted that certain groups (particularly those based on 12-step principles) could be overtly negative and confrontational, which increased attrition rates. Treatment therefore may benefit from ensuring that such groups are based in positive psychology, and avoid didactic and confrontational approaches. Regarding peer mentors, the

[61] Katherine (p. 120)

only notable criticism highlighted was the association between the approach and tribalism. Namely, peer mentors were at risk of pushing service users toward an approach that worked for them, as those were "the arrows in the quiver [they] reach for"[62]. This is a logical approach for peer mentors to adopt as they draw upon the skill-set they have acquired through lived experience, but may be problematic given that there is no universally effective and applicable treatment for those with co-occurring disorders (a) (Sacks, Ries and Ziedonis, 2005). Instead, treatment services should ensure that treatment plans are developed in collaboration with the service user with regard to their individual context and revisited regularly to assess progress (Strang *et al*., 2017).

The Importance of Giving Back in Recovery – A Pathway to Employment?

Employment is an important step in the recovery process (Best *et al*., 2013) and failing to secure employment post-treatment often results with relapse (Henkel, 2011; as cited in: McKay, 2017). It is an essential element of societal integration (Vangeest and Jonson, 2005) and helps service users develop social competence, self-efficacy (Maguire *et al*, 2014; Cano *et al*., 2017) and a new sense of identity, belonging and purpose - all of which help sustain recovery (Best *et al*., 2013; 2015) and are central features of wellbeing (Ryff, 1989). Employment also helps service users build new social networks to replace those associated with drugs, as well as occupy their free time (Best *et al*., 2015), which were both highlighted in the current study as key to the recovery process.

The vast majority of service users in the current study did not feel ready to return to work and felt it was important to prioritise their recovery, a perception that was supported by the treatment service. They believed that rushing to find a job would mean their recovery would take a step back and felt you should not "try to run before you can walk"[63]. Indeed, engagement with treatment was described as "a bit of a job"[64] itself, given the amount of time one must invest into it in order to succeed. That being said, participants consistently articulated the desire to 'give something back' once they were stable in their recovery. Service

[62] Owen (p. 149)
[63] Edward (p. 153)
[64] Morgan (p. 122)

users were passionate about helping others, particularly those with similar lived experience to their own. This is consistent with the concepts of generativity and 'the wounded healer' found within desistance literature (White, 2000; Maruna *et al*., 2004; McNeill and Maruna, 2007; Telepak, 2010; LeBel, Richie and Maruna, 2014). By converting previous experiences from a source of guilt or shame into a source of wisdom and insight, service users can overcome the labels associated with old, stigmatised, identities, replace them with more positive ones and reintegrate themselves within society (LeBel, Richie and Maruna, 2014). As the peer mentors in previous research (Maguire *et al*., 2014) and the current study articulated, this conversion is empowering; it helps solidify their own recovery and helps develop a positive identity based upon a newfound sense of purpose and optimism for the future.

Given the heightened levels of anxiety and depression associated with unemployment (Marmot *et al*., 2010; Ishmuhametov and Palma, 2017), securing employment is crucial once recovery is stabilised. Despite not feeling ready to return to full-time employment, participants of the current study expressed a desire to help others, suggesting that this may be a possible pathway to encourage employment among those with co-occurring disorders (c). While engagement in full-time employment may not be a realistic or sensible decision for service users who are less stable in their recovery, participants described the positive impact that helping others had on their wellbeing and expressed interest in the opportunity to volunteer in an area they found meaningful. Volunteering therefore, may represent a low-pressure opportunity to engage in meaningful work that could act as a stepping stone toward future employment and perhaps offer a way for service users to get a foot in the door of an organisation whose work they are passionate about.

The Department of Work and Pensions may represent a barrier to this pathway, however. A number of participants expressed finding it difficult to navigate the contrasting perceptions of the DWP and treatment services regarding employment. Some participants highlighted that they felt as though they were being forced back into work before they were ready and towards employment for the sake of employment, rather than being encouraged to pursue opportunities they found meaningful. This was, in part, as many found having to rely on inadequate benefits depressing and partly as they felt the DWP did not believe

volunteering was a valuable pursuit in terms of securing employment. The pursuit of work we find meaningful is an important aspect of our mental health and may help address anxious and depressive disorders (Hari, 2016). Therefore, the attitudes of the DWP towards volunteering opportunities in fields service users find meaningful may constitute a barrier to effective recovery.

Implications for Treatment Services

Employment is a central feature of social integration (Vangeest and Johnson, 2002) and represents an important stage of the recovery process (Best *et al*., 2013). However, as highlighted in the current study, service users felt it was important not to rush back into work and instead to focus on stabilising their recovery. Despite this, all service users expressed a desire to help others, particularly those with similar lived experience to their own. This suggests that promoting opportunities wherein service users are able to 'give something back' to their community, whether that is within the treatment centre itself or within the wider community, would be beneficial to the recovery process of those with co-occurring disorders (c).

Channelling this notable desire to help others into community and volunteer work could have a number of benefits for service users. For example, volunteering opportunities in areas that service users are passionate about may help cultivate a newfound sense of purpose and meaning which is associated with sustained recovery (Best *et al*., 2013; 2015) and improved wellbeing (Ryff, 1989), whilst also providing valuable experience within a field that they may wish to pursue a career in once they feel ready. Such opportunities would also help reintegrate service users back into society and their community, help address the stigmatised view of problematic substance users, and provide a further source of structure and routine beyond those associated with treatment. Volunteering may also act as a protective factor against those associated with relapse, such as isolation and boredom, by encouraging service users to build alternative, pro-social support networks that do not revolve around substance use treatment or recovery groups. This diversification of social support networks beyond the treatment sphere may be important to help some service users move on from treatment once it has concluded.

Transitioning into a role wherein service users are able to help others can also promote feelings of self-confidence, self-esteem, accomplishment and develop a sense of meaning and purpose (LeBel, Richie and Maruna, 2014). The current study suggests that helping others can have a positive effect on wellbeing (Ryff, 1989) and improve the self-worth of service users by offering evidence of capability, which reduced negatively valenced thoughts associated with perceived lack of ability to achieve. Taking on "little bits of responsibility"[65] seems to help service users develop the self-efficacy necessary for recovery and later employment opportunities (Maruna *et al*., 2004: 278).

Volunteering opportunities have been previously identified as an important facilitator of the recovery process for those with co-occurring disorders (a) (NICE, 2016) and the current study suggests they are also valuable for those with co-occurring disorders (c). However, while volunteering may offer a number of benefits, it would have to be supported by treatment services to ensure the work was not becoming too demanding and jeopardising recovery, given the strong association between stress and relapse highlighted in this thesis. Nevertheless, volunteering opportunities within the treatment service or in the wider community, may offer a low-pressure environment to build self-efficacy and engage in meaningful work that could act as a stepping stone towards part/full-time employment and improve the wellbeing of service users. As Christopher remarked: "Helping people just makes you feel good, doesn't it?"[66].

[65] Owen (p. 157)
[66] Christopher (p. 155)

Limitations

The current study does acknowledge some limitations. Firstly, the data is limited to one treatment centre in Swansea, meaning that results are difficult to generalise beyond this geographical location. However, results did highlight a number of commonalities with research conducted elsewhere.

Secondly, although interviews were in-depth and produced significant amounts of rich, textured data, the results are limited by the small sample size of this project. The limited resources and time-frame of an MPhil project meant that only nine participants were interviewed. Additionally, there was a marked gender imbalance in the sample, as only two women participated in interviews. This may mean results are difficult to generalise and some may not be relevant to all genders. However, as noted in the methodology, qualitative research on specific populations can identify elements that may embody the experience of those with similar lived experience. Therefore, the rich data provided through this research may provide a basis for future quantitative research with more statistical relevance.

Suggestions for Future Research

- The current research highlighted that although current policy favours collaborative treatment approaches between the mental health and substance use sectors, many participants highlighted their appreciation for an integrated treatment approach. Therefore, future research may benefit from ascertaining whether collaborative or integrated treatment would best serve this client group.
- This study highlighted the significant role that negatively valenced thoughts play in facilitating and exacerbating substance misuse. Therefore, further research into the efficacy of interventions that specifically address the thought process of service users with co-occurring disorders (c) may be beneficial. Mindfulness-based interventions may be of particular interest given their cost-effectiveness and general applicability to a range of disorders.

- Chapter Five highlighted the significant positive impact that communal, diversionary activities may have for service users with co-occurring anxiety and depression. However, there is very little contemporary research on this topic. Therefore, more research is required to examine the efficacy of this treatment intervention.
- Although in contrast to other participants, one service user mentioned her reluctance to pursue and develop friendships within treatment as she felt it would prevent her from moving on. Future research may benefit from exploring whether the friendships developed within treatment and recovery hinder an individual's ability to progress beyond the treatment/recovery sphere, and whether service users should be encouraged to diversify their support networks to address this.
- While the negative impact that surviving on benefits can have on mental health and their exacerbatory effect on mental illness has been previously documented, future research may benefit from exploring the conflicting opinions that the Department of Work and Pensions and substance use services hold with regard to employment. The current study has highlighted that service users struggle to contend with this conflict of opinion and feel dismayed at having to go against the advice of their treatment centre in order to fulfil their obligations to the Job Centre. Moreover, given that volunteering opportunities are a salient pathway toward paid employment for many service users, the perspectives of the Job Centre on this issue should be examined and evaluated.

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Appendices

Appendix A:

Introduction

1. General chat
    a. What my research is and why they've been selected
    b. Discuss confidentiality and anonymity
    c. Are they happy for this to be audio recorded, as it'll help me a lot when I come to writing up my results
    d. Show consent forms, go over them with them and ask if they're happy to sign them
    e. Give a brief intro to the interview and what we'll be covering - During the course of this interview I want to start off by talking with you about your current treatment and then I want to chat about your history of substance use, and anxiety and depression

Treatment - 1

How are you finding your treatment here?
How long have you been receiving support here?
What treatment are you receiving? How did you find out about it?
Expectations? Experiences?
Do you think you've improved since being on the program?
If no, what could be done to improve it?
Does your treatment address other problems you're having?
What do you enjoy about your treatment here?
What do you find most helpful (+frustrating
Social life outside of treatment?
*How do you get on with other clients? – **examples** but no names*

Drug use

I'd like to step back now and talk a little bit about your history and what you've found helpful during your journey to where you are now…

When was it initially problematic?
What was happening around the time?
What made you seek treatment?
What stopped you before?
Role of stress? What helps with it?
Last used? Feelings now you've stopped?

Mental illness

When did it begin? What was happening around the time?
MH treatment? Since when?
What stopped you seeking it sooner?
Expectations? Experiences?
What helps with low moods?
Activities that help?
Is SU treatment helpful for MH? How?
MH impact on drug use and treatment?

Employment - 2

Job? Do you enjoy it? (Why?)
Is employment important to you?
What would you like to do? What are your plans?
How does your case worker feel about you getting a job?
What about MH worker?
Are you aware of any employment services here?
What do you think about the job services here?
How did you find out about them?
Expectations? Experiences?
Can they be improved? Often quiet – why?
Computer competency?
Would you find a class on basic computer skills useful?

Substance use and mental illness

Do you think your drug use effect your mental illness?
Do you think having a mental illness effects your treatment here?
How is it different from those who don't?
Which do you think needs to be tackled first?
Do you think your experience of treatment is the same as other people who have a MH issue?
Does your mental health worker ever speak to your case worker here?

Improvements - 3

Changes you'd like to see?
Animal therapy – how do you feel about that?
Do you think it would benefit mental wellbeing?

Future

Where would you like to see yourself in a few years' time?

End of interview
Thank you for participating
Your voice and views are important because…
Any questions?

Appendix B:

Participant Information Sheet

Research Topic: Evaluation of Substance Misuse Treatment

Researcher's Contact Details:

Gethin Jones - **gej23@aber.ac.uk** – 01970 622712

Before completing the interview, it is important for you to know why I am doing this work and what it will involve. Please take the time to read the information sheet carefully and if there is anything you do not understand or are unsure of, please feel free to ask me. Thank you.

Your caseworker will be in the building and available during the interview should you need anything.

Purpose of the project
To understand how your treatment at WCADA is going. This will hopefully help WCADA to improve their work with you and other people in the future.

Why have you been chosen?
You have been asked to take part because you worked with WCADA on your substance misuse and have valuable insight into what I am researching.

Do you have to take part?
You do not have to take part; this is not part of your work with the WCADA service. It is your choice and you do not need to tell anyone why you make that choice. If you choose to talk to me, I will be very interested in listening to your experiences with WCADA. You can change your mind and stop at any time and you do not need to give any reasons. You can refuse to answer any question and again you do not need to explain. If, after the interview, you want to withdraw please let me, or your WCADA worker know and I will remove you and any information you gave from the research, you do not need to tell me why you want to withdraw.

Will my participation be confidential?
Yes, you will not be named or identified in any way in the research. The interview will be recorded with your permission but all information will be kept in a way that ensures other people cannot get hold of it and your name will not be stored with it. Your confidentiality will be respected unless disclosure is necessary for the safety and wellbeing of either you and/or others.

Supervisors' contact details in case you have any problems with the research:

Alan Clarke – ahc@aber.ac.uk - 01970 622718
Brendan Coyle - brc8@aber.ac.uk - 01970 621930

Appendix C:

Practitioner and Management Information Sheet

Study Title: Evaluation of Substance Misuse Treatment

Researcher: Gethin Jones

This research project is independently funded by KESS. I am a post-graduate student based at Aberystwyth University, working with WCADA who is my partner in the sector.

Aims of the Research

I will be conducting a survey, interviews and case studies with those working in the field of substance-misuse and mental health treatment. This will include staff and volunteers of treatment programmes willing to share their experience with us. The aim is to understand the implications that mental illness has on successful substance misuse treatment and to record factors which indicate positive outcomes along an individual's pathway to recovery. This research will hopefully lead to more successful substance misuse treatment being implemented in the future, allowing clients greater opportunities post-treatment.

Why have you been asked to take part?

You have been asked to take part because you work in the field of substance misuse. Participation is entirely voluntary. Your identity will be kept confidential and all information provided will be made anonymous.

What will happen if you agree to take part?

If you agree to take part, the interview will last between 60 and 90 minutes.

What are the possible benefits of taking part?

This research offers you the chance to speak to an interested, independent person outside of your organisation. The findings will improve working practices in the sector and inform government and policy makers.

What are the possible risks or disadvantages of taking part?

There are no obvious risks to taking part in this study. You will not be identifiable in any reports and neither will your organization. Further, if you feel like you want to retract, clarify or add anything after our meeting, you will be able to do so by contacting us.

How will your information be used?

If you consent, your interview will be recorded and transcribed. I may use some statements from participants as quotes in my final thesis and in any presentations or other outputs. These quotes will be anonymous.

How will your confidentiality and anonymity be protected?

Your name will remain confidential once the interview has been transcribed and all other identifying information will be removed.

If you have any concerns about your confidentiality and anonymity, please contact me or my supervisor so we can discuss them.

Who do you contact if you would like more information?

If you would like any further details about the project, please feel free to contact me:

Researcher: Gethin Jones

Address:

E-mail: gej23@aber.ac.uk

Phone: 01970 622712

Who do you contact if you would like to raise any issues with the research?

If you are unhappy with, or wish to feedback regarding the conduct of this research project, you can contact my supervisors (see above)

Supervisor: Alan Clarke

Address: Room 1.30, Elystan Morgan Building, Llanbadarn, Aberystwyth, Ceredigion, SY23 3AS

E-mail: ahc@aber.ac.uk

Phone: 01970 622718

Supervisor: Brendan Coyle

Address: Room 2.11, Elystan Morgan Building, Llanbadarn, Aberystwyth, Ceredigion, SY23 3AS

E-mail: brc8@aber.ac.uk

Phone: 01970 621930

Appendix D:

Consent Form

Research Topic: Evaluation of Substance Misuse Treatment

Name of Researcher: Gethin Jones – gej23@aber.ac.uk - 01970 622712

Participant Identification number:

1. I have read and understood the information about the study ☐
2. I have asked all the questions I want to ask ☐
3. I am happy to be interviewed and I know that I can leave at any time or refuse to answer any questions ☐
4. I agree to researchers using my words as long as no-one can work out who I am ☐
5. I know that I can ask for you to destroy anything about me up until my name is taken off the information. ☐
6. I agree to the interview being audio recorded ☐
7. I agree to allow my information (without my name) to be used for future research projects. ☐

I consent to taking part in this Research Project.

Name of Participant: .....

Signature: .....

Date: .....

Supervisors: **Alan Clarke – ahc@aber.ac.uk - 01970 622718**
Brendan Coyle - brc8@aber.ac.uk - 01970 621930

Appendix E:

Client Participation Debrief Sheet

I would like to thank you for taking the time to participate in my research. The aim of the study will be to help find out what impact a mental illness has on substance misuse treatment to hopefully aid WCADA in improving their treatment for you and others in the future.

If you have any questions about the research please feel free to contact me or ask your WCADA support worker to get in touch with me and I will be happy to help in any way I can. My email is provided below.

If you have any problems regarding the project, my supervisors' emails will also be provided below. Alternatively, you could ask your WCADA support worker and they can get in touch with them for you.

Researcher: Gethin Jones – gej23@aber.ac.uk - 01970 622712

Supervisors: Brendan Coyle - brc8@aber.ac.uk - 01970 621930
Alan Clarke – ahc@aber.ac.uk - 01970 622718

Appendix F:

Overview of Participants Sampled for Interview

Christopher	Christopher began using a variety of drugs in his teenage years but entered treatment for his heroin and alcohol use, which he developed a problem with in his mid-twenties. Christopher's problems with anxiety and depression developed in his late-twenties and he took anti-depressants periodically for this, although the negative side-effects dissuaded him from using them for long periods. - Engaged with Alcoholics Anonymous and the DOMINO Project, with minor involvement with Cyfle Cymru.
Katherine	Katherine had been a polysubstance user since she was an early teenager but entered treatment for her heroin use. She has suffered from anxiety and depression since her childhood, which she associates with being sexually abused at this time. She has been prescribed various anti-depressants since she was a child and receives counselling through WCADA. - Engaged with the DOMINO and Cyfle Cymru service, and also received some support through Community Outreach service.
Owen	Owen entered treatment for help with a variety of drugs, predominantly alcohol and amphetamines. Owen has suffered from anxiety and depression throughout his life, and has received private external psychological therapy (as he was unable to access this via the NHS). He is appreciative of this therapy but still struggles with anxiety and depression and continues to take anti-depressants to help with it. - Engaged with the DOMINO Project, Cyfle Cymru.

Vaughn	Vaughn had used a variety and substances throughout his life but he entered treatment for his alcohol and cocaine use. Vaughn had suffered from anxiety and depression since he was a teenager but was only prescribed anti-depressants recently. - Engaged predominantly with the DOMINO Project and Alcoholics Anonymous.
Emily	Emily entered treatment for her alcohol use, which she has struggled with since the beginning of an abusive relationship in her twenties. She attributes her problems with mental illness to this relationship and its consequences. She continues to take anxiety and anti-depressant medication, and receives counselling through WCADA. - Engaged with the DOMINO Project, Cyfle Cymru, and had some assistance from the Community Outreach service.
Keith	Keith had only recently began engaging with WCADA for his cocaine use, following a referral from an external organisation. He had used a variety of substances extensively until his mid-twenties and used cocaine exclusively for 15 years after this. He had suffered from anxiety and depression since he was a teenager, although these conditions had exacerbated in later life. He is currently on a lengthy waiting list for psychological therapy, after failing several times to secure it, and he continues to take anti-depressants. - Engaged with the Cyfle Cymru service
Morgan	Although he experimented with various drug in his teenage years, Morgan entered treatment for heroin use, which he has been using periodically for 15 years starting in late adolescence. He had suffered from both anxiety and depression since around the same period. He received anti-depressant treatment for this, but did not receive any psychological therapy

	until he engaged with the counselling service at WCADA. - Predominantly engaged with the DOMINO Project.
Nathan	Nathan experimented with a variety of drugs in his teenage and late adolescent years, especially with ecstasy and heroin. However, he entered treatment for his problems with alcohol. Despite failing to initially, Nathan now receives external psychological therapy and has been on various courses of anti-depressants since his mid-twenties. - Engaged with the DOMINO Project and Cyfle Cymru services.
Edward	Edward entered treatment for his alcohol use. Although he had used a variety of drugs recreationally and drank socially most weekends, he did not believe this became problematic until he was in his early forties. Edward had suffered from anxiety and depression throughout his life, beginning in his adolescence and he received psychological therapy throughout his twenties to help address his problems with anxiety. He was prescribed anti-depressants in his thirties and continues to use them to help him manage his anxiety and depression. - Engaged with a variety of treatment services including Alcoholics Anonymous, the DOMINO Project and Cyfle Cymru.

* It should be noted that all interview participants were middle-aged and the majority also received counselling through their support worker.

Appendix G:

Examples of Field Notes

20/11/2017

DOMINO/Cyfle Cymru Structured Walk **[10:00 - 14:30]**

Went along on a structured walk offered by the DOMINO project to the beautiful Lliw reservoir. A very enjoyable adventure despite the rain and everybody enjoyed themselves. Also gave me a chance to have inform talks with a few service users and staff. "T" – was a heroin and crack addict for 20 years, he believed this worsened when his father passed. He has been coming to WCADA for 7 months now which is helping a great deal, and going along to cooking classes and DOMNIO walks which improve sociability and motivation. He had also been attending computer classes provided by Cyfle Cymru to improve his computer literacy, which helps with employment prospects.

A few service users mentioned their anticipation of DOMINO walks as it gives them something to look forward to at the beginning of the week, where they can "escape the busyness of everyday life" by exploring the countryside with fellow service users – it motivates them and gives them something to focus on and look forward to on a Monday morning. There was a good turnout for the walk, despite the terrible weather, which speaks wonders for the activity and its usefulness to clients. Happy atmosphere throughout the entire walk, and tea and biscuits when we got back to the bus! Many service users are keen and motivated to improve their employment prospects by doing volunteering or engaging with computer literacy courses.

11/01/2018

Personal Development **[9:30 - 11:00]**

Second half of two-part session on confidence and self-esteem and a full room present for the class today. Open discussion again following the work booklet. The peer mentor running the group has many profound insights into how to deal with negative thoughts, which seem to resonate with both clients and myself. In fact, the group often share many profound insights, examples and quotes to challenge negative thoughts, which they share with one another.

This course really makes service users challenge their own negative thoughts – many examples given by group of times their negative core believes had been challenged by events/people in their lives – benefit of group therapy is the range of ideas and opinions which are provided. There were some deeply emotional examples given – one service user explained the reason behind many of her negative core beliefs was an abusive partner who consistently berated her physically and emotionally telling her she was worthless and unlovable – group challenged this by highlighting that her children love her so how can

those beliefs be true?

Another example: service users expressed a core belief he used to hold: "I'm boring without drink" – highlighted for me underlying mental health and confidence issues underpinning substance-use. This was challenged by the peer mentor who highlighted that he has never thought he was a boring person, despite never having met him drunk. *Do users begin to believe that only through substances can you be your normal self?*

There is a 'we're all in this together attitude' which permeates throughout the group, enhancing the sense of comradery which I believe helps and creates a good sense of community within the treatment setting. Another good example of this comradery arose during the session when one service users become visibly upset whilst discussing the negative thoughts she has. The other service users were quick to reassure and comfort her, challenging the negative thoughts she had of herself.

It was lovely to see many of those who came in subdued and withdrawn ending up laughing along with the group – *lots* of laughs in the session today.

13/02/2018

Allotments **[10:00 - 12:30]**

Cleared debris and tidied up the allotments, picking up litter etc. Made teas and coffee to keep from the cold. The allotments are mostly a social activity it seems, providing a space outdoors where service users can interact with one another around the fire and chat. There are many practical things to complete whilst there though which seem to have very positive effects amongst users. The sense of achievement and accomplishment which go alongside gardening and watching your work grow before you serve as an apt metaphor for the personal growth which service users are going through during their recovery, and one which I'm sure is not lost on them. There is once again, an impressive display of skill on show at the allotments. Service users had built 3 sheds from scratch to house tools and seeds etc., and a shelter in which to hide from the elements if need be. The shelter, impressively, was built entirely from old wooden pallets which they had acquired and a tin roof to keep the rain out.

Everyone had a job to get on with – 'T' tended to vegetable patches. 'D', two peer mentors and myself cleared the rear of the allotment of debris. 'G' built make-shift shelves in the shed whilst we were there to hold all the wood for the fire.

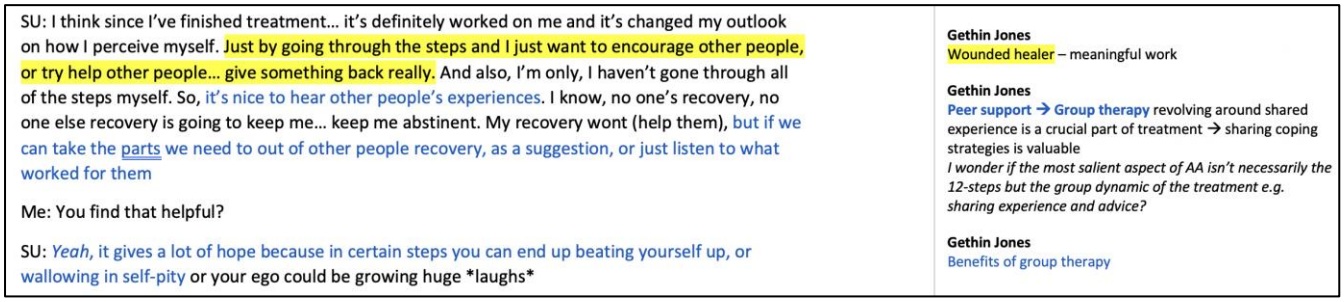
Guitar Sing-along **[2:30 – 4:30]**

Pleasant group sing along. Relaxed atmosphere where anyone can pick up a guitar and join in if they wish, or they can just play the drum or sing along so that no one is excluded. It lifts the moods of everyone present playing and singing along to the same songs together – *music seems to be an excellent tool within recovery, and promotes a sense of community*.

Appendix H:

Examples of Coding Process

Example of the annotations made to transcripts (Stage One and Two):



SU: I think since I've finished treatment… it's definitely worked on me and it's changed my outlook on how I perceive myself. Just by going through the steps and I just want to encourage other people, or try help other people… give something back really. And also, I'm only, I haven't gone through all of the steps myself. So, it's nice to hear other people's experiences. I know, no one's recovery, no one else recovery is going to keep me… keep me abstinent. My recovery wont (help them), but if we can take the parts we need to out of other people recovery, as a suggestion, or just listen to what worked for them

Me: You find that helpful?

SU: *Yeah*, it gives a lot of hope because in certain steps you can end up beating yourself up, or wallowing in self-pity or your ego could be growing huge *laughs*

Gethin Jones
Wounded healer – meaningful work

Gethin Jones
Peer support → Group therapy revolving around shared experience is a crucial part of treatment → sharing coping strategies is valuable
I wonder if the most salient aspect of AA isn't necessarily the 12-steps but the group dynamic of the treatment e.g. sharing experience and advice?

Gethin Jones
Benefits of group therapy

A further example of the coding frame (Stage Three):

Support network	Informal	Sense of community / Peer-group support (Internal)
		Socialisation with other service users (external)
		Familial support
		"We're all in the same boat here" / relatability
	Formal	Group therapy
		Peer mentor support
		Staff support for various life difficulties
		Positive relationship with staff
		Mental health support / counsellor
		Attitude of Job Centre work coach

Example of the word document containing various snippets of interview (including interview and page number e.g. 4:8) that corresponded with a particular code and colour e.g. 'Drug use as a coping mechanism [orange]' (Stage Four):

Drug use as a coping mechanism

"It is scary every day, because it's a battle every day. Trying to… stop going back into that… way of dealing with things." **(4:8)**

"Uh, all the reasons I was using drugs started to disappear as I became more structured and capable to deal with things." **(3:24)**

"I would be wired all that week, and I did think about having a drink and I, that's the only time I thought 'I know I'll get rid of this feeling' and I went *pause* 'I'd rather go home and take a Valium.'" **(2:10)**